System Focus

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The Impact of COVID-19 on Mental Health

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Before COVID-19 began, the United States was already in an epidemic of deaths of despair, with an anticipated 150,000 lives lost to alcohol use, drug overdose, and suicide—one that led to declines in life expectancy three years in a row (see **Exhibit 1** on the following page).[1] The Well Being Trust and Robert Graham Center recently released a report that projected that the COVID-19 recession would lead to between 27,644 and 154,037 additional deaths of despair.[2] This "second curve" of a mental health epidemic will not affect everyone equally. This article will describe who is affected, why, and what can be done to mitigate the second curves of diseases of despair.

Key Board Takeaways

Five key questions boards should be asking themselves:

1. Are we approaching the COVID pandemic as an isolated biologic pandemic, or are we prepared to address the secondary curves of financial insecurity and diseases of despair?
2. How are we attending to our workforce? Are we prepared to assess and meet their mental health needs now and over the next several years?
3. Are we ensuring that we are connecting the dots for our patients, our workforce, and our communities in supporting their financial security, healthcare coverage needs, good mental health access, and sense of hope and resilience?
4. Is our response equitable? Are we stratifying and understanding how people are doing based on race/ethnicity, place (zip code), etc.? Are we set up to meet the needs of our most vulnerable people and communities?
5. How well are we taking advantage of the opportunities of this moment to advocate for deep systemic change?

Who Is Affected?

While nearly everyone is affected in some way, some groups are disproportionately affected by poor mental health outcomes in the context of COVID-19. This article focuses on two groups: people experiencing unemployment or financial insecurity (including racial/ethnic minorities) and healthcare workers at the frontlines. Older adults who were already experiencing social isolation are expected to also experience significant mental health impact, but this has not yet shown up in the data.

1. Unemployment and Financial Insecurity

According to a Gallup poll conducted between May 15–17, 2020, 53 percent of Americans are very or somewhat worried that they will experience severe financial hardship in the context of COVID-19, with 17 percent being very concerned about this.[3] A Kaiser Family Foundation poll found that half of those employed in February 2020 say they have lost a job, become unemployed, or lost income since the pandemic began, and 54 percent of those who have lost income or employment reported a negative impact on their mental health.[4]

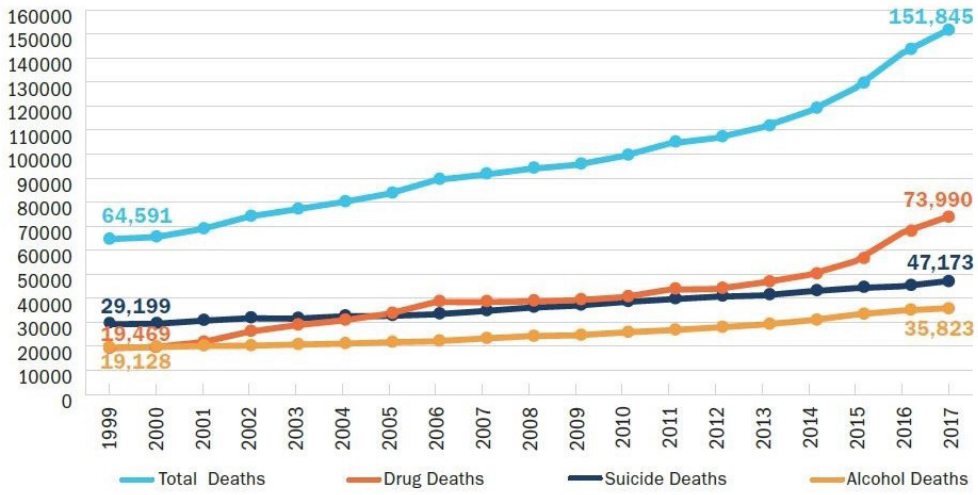
1 Trust for America's Health and Well Being Trust, *Pain in the Nation Update: While Deaths from Alcohol, Drugs, and Suicide Slowed Slightly in 2017, Rates Are Still at Historic Highs*, Issue Brief, March 2019.

2 Steve Petterson et al., *Projected Deaths of Despair from COVID-19*, Well Being Trust and Robert Graham Center, May 8, 2020.

3 Frank Newport, "Gauging Concerns About Americans' Personal Finances," *Polling Matters*, Gallup, May 22, 2020.

4 Nirmita Panchal et al., "The Implications of COVID-19 for Mental Health and Substance Use," Kaiser Family Foundation Issue Brief, April 21, 2020.

Exhibit 1: Annual Deaths from Alcohol, Drugs, and Suicide in the United States, 1999–2017



Source: Trust for America's Health and Well Being Trust analysis of data from National Center for Health Statistics, CDC

This concern is not distributed equally among Americans. Women, especially parents, are particularly affected as they take on a disproportionate burden of caregiving[5]—68 percent of hourly workers and 62–65 percent of those earning incomes less than $90,000 reported this compared with 38 percent of those whose income was $90,000 or higher.[6] According to the Bureau of Labor Statistics, less than half of black adults now have a job (see **Exhibit 2** on the following page).[7]

Those who are most affected are likely to be the same families who have less ability to cope with hardship, might lose health insurance, and have a harder time paying for non-COVID-19 medical and life expenses, especially in non-Medicaid expansion states. Seventy-five (75) percent of Americans feel like the worst is yet to come[8]—and those who feel hopeless that conditions will change in the long term are particularly at risk for diseases and deaths of despair.[9]

Bright spot: The Delaware Division of Substance Abuse and Mental Health used five questions from the Well Being In the Nation measures[10] in real time to understand who in the population of people with mental health and addictions was thriving, struggling, or suffering, who had hope, and why. They found that financial insecurity and loneliness were playing a major role and, in their capacity as treatment providers and care managers, connected people with employment, housing, and legal supports to address these challenges.[11]

5 Ashley Kirzinger et al., "KFF Health Tracking Poll—Early April 2020: The Impact of Coronavirus on Life in America," Kaiser Family Foundation Issue Brief, April 2, 2020.
6 Panchal et al., April 21, 2020.
7 Jeanna Smialek and Jim Tankersley, "Black Workers, Already Lagging, Face Big Economic Risks," *The New York Times*, June 2, 2020.
8 Kirzinger et al., April 2, 2020.
9 Carol Graham, "American Optimism, Longevity, and the Role of Lost Hope in Deaths of Despair," Brookings Issue Brief, November 7, 2019.
10 See www.winmeasures.org.
11 Internal Division of Substance Abuse and Mental Health (DSAMH) data.

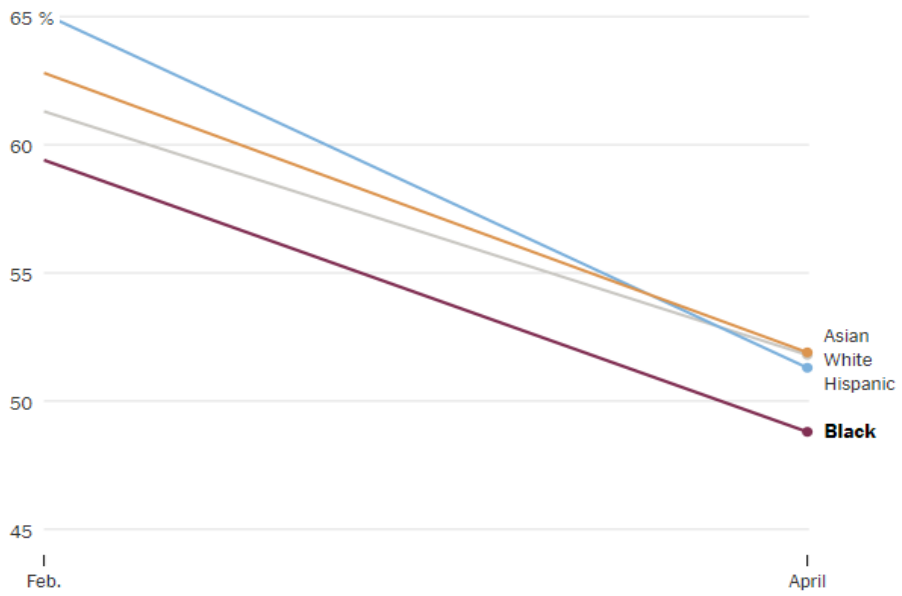
Key Board Actions

A few key actions that boards can take are detailed below:

1. Ensure that the organization is paying living wages to all of its workers, including community health workers who may be involved in the COVID-19 response.
2. Use a portion of investment or other funds to create a "rainy day" fund for employees to use or borrow against to ride out unexpected expenses. This can substantially reduce stress in the workforce. This is a time to invest in your people.
3. Ask the management team for a plan to assess and safeguard the mental health and well-being of the healthcare workforce. Ask for data in particular about how employees from racial/ethnic minorities are doing.
4. Understand whether employee benefits include adequate, low-cost coverage for mental health services.
5. As a board member, work to connect your health system to the broader community. Bring the needs of the health system to the community and learn what the community needs that the health system can help with. We are only going to make it through this pandemic if we understand we are all in this together.

Exhibit 2: Less Than Half of Black Adults Now Have a Job

Share of population working before and after the pandemic shutdown began, by race and ethnicity



By The New York Times | Source: Bureau of Labor Statistics

2. Healthcare Workers on the Frontlines

The pandemic has been particularly difficult for frontline healthcare workers across the globe for a number of reasons. In China, where this has been better documented, 22.4 percent of healthcare workers had moderate disturbances and 6.2 percent had severe disturbances to their mental health in the context of caring for people with COVID-19 in Wuhan, China. In the U.S., growing attention has been drawn to these risks by mental health professionals, like Dr. Jessica Gold, Assistant Professor in the Department of Psychiatry at Washington University in St Louis School of Medicine, who notes, "The mood among my co-workers is of impending doom and existing gloom."

Dr. Gold cites several reasons: 1) the initial lack of personal protective equipment; 2) the fear of getting or spreading the virus to patients and families, which often leads healthcare workers to isolate from their family and support systems; 3) the act of actually being quarantined, which has had a serious impact on mental health of healthcare workers during the SARS epidemic, leading to symptoms of acute stress disorder, depression, and alcohol abuse, with post-traumatic stress disorder persisting for over three years. Many are afraid they might die; many hospitals have included drafting of living wills as part of their COVID-19 preparation.

Perhaps the most pernicious of all of this is feelings of betrayals—by healthcare, the government, and those who should have been prepared. Healthcare workers are afraid they will be asked to close the breach in a system that is made by others, will be asked to make decisions that cause moral harm, and will need to work in areas they have not worked in for years. Compounded in all of this is feelings of grief or failure for patients who have been lost and for racial/ethnic minorities who may be experiencing compounding issues related to intersecting racism from police violence and COVID-related disparities.

Bright spots: Kaiser Permanente has begun a workforce well-being survey that includes mental health, overall well-being, and financial security. Hospitals in Wuhan, China, the University of North Carolina at Chapel Hill, and the University of California, San Francisco, have proactively deployed their psychiatric workforce to care for their colleagues. Their approaches range from stress reduction, mindfulness, and educational supports to in-the-moment crisis supports to treatment.

A June 2020 article by Dr. Neil Greenberg, Professor of Defence Mental Health at the NIHR Health Protection Research Unit in Emergency Preparedness and Response at King's College London, proposes the following steps for the healthcare management team:[12]

1. Thank healthcare workers appropriately and openly (it is important for the board to do this as well). Proactively acknowledge and normalize psychological difficulties and provide information about where support options are available.
2. Contact staff who do not show up to work in case this avoiding behavior is due to poor mental health.

12 Neil Greenberg, "Mental Health of Healthcare Workers in the COVID-19 Era," *Nature Reviews Nephrology*, June 19, 2020.

3. As the COVID-19 pandemic comes under control, have supervisors perform "return to normal work" interviews as staff members transition back to routine work. These interviews need to include discussions about mental health, staff members' experiences, and should normalize mental health impacts of the pandemic. These discussions can reduce absences and help staff seek help.
4. Check in particular on healthcare workers in high-risk groups, such as those from black and minority backgrounds who may be experiencing high levels of loss from the impact of the pandemic in their community and from ongoing trauma from racial inequities. Community health workers at the frontlines should receive particular attention.
5. Proactively monitor the mental health and well-being of anyone who has been involved in a potentially traumatic event. In addition, anonymous self-check tools with tailored advice and self-help and ways to access care can increase health professional use.
6. Help staff make sense of their narratives in a way that does not blame themselves or others. This can reduce the risk of moral injury over time.

All of these approaches emphasize that mental health treatment is not just something that happens urgently or in crisis, but rather is something that needs to continue and be available long into the future.

The COVID-19 pandemic has revealed the connection between physical health, mental health, economic insecurity, social needs, and racial and other inequities. It's up to boards to use this knowledge and their privilege to create a connected and equitable health and community system that helps to create well-being for everyone.

The Governance Institute thanks Somava Saha, M.D., M.S., Founder and Executive Lead, Well-being and Equity (WE) in the World, and Executive Lead, Well Being in the Nation (WIN) Network, for contributing this article. She can be reached at somava.saha@weintheworld.org.