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Short Communication

Don't Postpone! Mental Health of Healthcare Professionals Needs Attention!

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Abstract

The consequences of the coronavirus disease 2019 (COVID-19) pandemic on the perceived workload of health care professionals and remaining mental symptomatology are becoming increasingly visible. Increasing waiting lists and workload and decreasing employee capacity in mental health services will contribute to the problem of health care availability. In several studies, many of the responding mental health care workers (MHCWs) reported stress-related complaints and depression. Moreover, more clients with complaints, as a direct and indirect result of the COVID-19 pandemic, requested mental health care. Support for mental health care staff is needed to prevent further escalation. These insights trigger an appeal to government and mental health institutions to take responsibility for protecting MHCWs. This requires the right decisions and investment in the prevention and mental health support for MHCWs! Preparing health care professionals for future challenges by focusing on interventions early in their career, which improve mental stability to enhance resilience, seems to be important to prioritize.

Introduction

The COVID-19 pandemic, known as the global pandemic of coronavirus disease 2019 (COVID-19), is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). In January 2020, the World Health Organization (WHO) declared the outbreak a public health emergency of international concern. As attempts to contain this pandemic failed, the virus spread worldwide in 2020. On May 4th, 2023, the WHO Director-General determined that "COVID-19 is an established and ongoing health issue that no longer constitutes a public health emergency of international concern" (https://www.who.int/news/). However, the extent of the global pandemic due to COVID-19 has had a significant impact worldwide, with consequences on crucial aspects of daily life globally, including food security, the global economy, education, tourism, hospitality, sports and leisure, gender relations, domestic violence/abuse, environmental air pollution and mental health.[1] The widespread backlog in healthcare provision increases pressure on health care workers, particularly with regard to hospital and specialist care.[2] The health care system needs support to cope with the high prevalence of mental health care problems. Eurofound reports an increase in unmet mental health care. This paper will specifically focus on the mental health of mental health care workers (MHCWs).

At the beginning of the COVID-19 pandemic, every effort was made to improve the well-being of hospital staff. After all, they had to make a permanent heavy effort daily on an unpredictable scale. In line with the COVID-19 pandemic, problems have emerged that have not been previously addressed, such as those in the mental health care sector. The mental health status of MHCWs deteriorated as a result of the pandemic.[3] The measures imposed by the government to regulate the pandemic had far-reaching consequences for this field of study. Growing tension, anxiety and gloom complaints were reported due to isolation, disruption of work and dropout. Therefore, working in mental health care became more stressful, even though the number of related measures was gradually reduced. Recently, the WHO has indicated concern about health care workers during the COVID-19 pandemic, especially regarding mental complaints among health care providers, such as mental fatigue and overstrain.[3] This paper aims to illustrate the consequences of the

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Abbreviations: COVID-19, coronavirus disease 2019; MHCW, Mental Health Care Workers; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; WHO, World Health Organization.

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COVID-19 pandemic for MHCWs and stresses the importance of paying attention to the working conditions of MHCWs and providing support for employees in this sector.

Methods

The Don't Forget Yourself study: during the pandemic

In 2021, the Don't Forget Yourself study was conducted in the Netherlands among MHCWs by De Vroege and Van den Broek.[4] The survey was distributed via social media (LinkedIn) and by administrators of large mental health institutions in the Netherlands. A total of 1,372 responses were received from MCHWs, who were working for more than 20 institutions throughout the country.

The MHCWs are permitted to use the survey data for research. Ethical approval for the survey studies was given by the appropriate institutional review committee: the scientific board of the Mental Healthcare Institute, GGz Breburg. The ethical guidelines of the Helsinki Declaration (as revised in 2013) were followed.

Results

The study by De Vroege and Van den Broek,[5] showed that the previously mentioned deterioration in mental health among hospital staff was also observed in the mental health sector in parallel with the perceived high workload and sustained pressure. In this study, a substantial proportion of MHCWs reported experiencing adverse effects due to the COVID-19 pandemic. For instance, 50% of the respondents experienced more stress and tension compared to the period before the COVID-19 pandemic, and 30% reported an increase in feelings of depression and gloom, and mentioned that these complaints were mainly caused by the pandemic.

The worsening of pre-existing complaints was also attributed to the pandemic. Moreover, 34% of the respondents stated that the work/life balance shifted to work, leading to increased pressure. In general, they had not taken more sick leave or more days off. When being asked whether they would like to organize work differently in response to the COVID-19 pandemic, 31.5% indicated that they liked to stay at home more, 7.5% would like to work fewer hours, and 4.2% of the respondents considered quitting work. The latter can have a considerable impact, as the mental health care sector was already struggling with capacity problems before the pandemic.

The Don't Forget Yourself study: after the pandemic

The online study was repeated in 2022.[6] In this second survey, 510 MHCWs participated. This recent study (which compared 1,372 MHCWs during the pandemic with post-pandemic 510 MHCWs) showed that levels of anxiety ($X^2 = 41.97$, $p < 0.001$, $V = 0.15$), stress ($X^2 = 24.37$, $p < 0.001$, $V = 0.11$), depression ($X^2 = 27.2$, $p < 0.001$, $V = 0.12$), sadness ($X^2 = 13.99$, $p < 0.001$, $V = 0.09$), and anger ($X^2 = 12.94$, $p = 0.002$, $V = 0.08$) were significantly higher and/or more prevalent during the pandemic compared to the post-pandemic period. Furthermore, the results show a rather troubling phenomenon (in light of employee capacity): respondents stated that they had taken more sick leave after the pandemic ($X^2 = 55.57$, $p < 0.001$, $V = 0.17$), had taken more days off ($X^2 = 29.11$, $p < 0.001$, $V = 0.13$), and "were more absent post-pandemic than during the pandemic" ($X^2 = 39.58$, $p < 0.001$, $V = 0.15$). This may be a result of MHCWs who had stayed on during the pandemic and taken on the work of their absent colleagues and are now exhausted. These MHCWs began prioritizing their own well-being and addressing fatigue now that it finally seemed possible. These results are alarming in multiple ways (*i.e.*, more pressure on health care capacity, a growing waiting list and more).

When comparing situations during- and post-pandemic, the number of experienced mental health complaints decreased significantly post-pandemic which can be considered a positive outcome. The majority of respondents indicated that they had restored their work-life balance post-pandemic. However, more sick leave and more frequent absences were reported post-pandemic than during the pandemic. These phenomena may be linked to the high resilience of MHCWs during extreme situations despite the presence of mental complaints. This highlights the importance of focusing on resilience both in training and professional careers. Research in other countries showed similar outcomes with substantial complaints of stress, anxiety, and depression among MHCWs.[7] A recent study in the *Lancet* reported increased prevalence rates of depression and anxiety disorders due to the COVID-19 pandemic, particularly among women.[8] This overall increase can be generalized to all MHCWs. Considering more women than men are engaged in mental health care, the abovementioned research results are an even more substantial warning for the mental health sector.

The evolving mental health care setting

The increase in mental complaints among MHCWs increases the uncertainty of the situation within mental health care. Additionally, waiting lists in mental health care increased due to the influx of COVID-19-related patients. The increasing demand for care is pertinent to individuals who have complaints due to the COVID-19 pandemic and related measures or have (permanent) complaints after infection with SARS-CoV-2 and who are referred to (specialist) mental health care after physical rehabilitation. Rehabilitation programs focus primarily on physical complaints. Attention should also be given to the psychological consequences of COVID-19. When physical symptoms persist or no longer decrease, the process of accepting the continuation of these complaints follows. New coping behaviors must be taught to handle the comorbid, neurocognitive and mental complaints that have developed. Because of the overlap with somatic symptoms and related disorders,[9] the remaining symptoms after COVID-19 are often classified as somatic symptom disorders, leading to referral to specialized mental health care, which further increases the number of patients on the waiting list.

In addition to COVID-19-related mental complaints, depression has increased in the population due to feelings of loneliness and the absence of activities outside due to governmental measures.[10] The MHCWs entered a negative spiral, from which a large group was still unable to escape independently. The treatment options for these complaints were limited due to the governmental pandemic measures, causing a sense of helplessness among MHCWs (inability to conduct group sessions or maintain structured programs). In addition, the relevant measures also caused increasing agitation inside and outside of mental health care, even in treatment rooms (for example, discussion on mask obligation).

The anti-government thinking and distrust of the government became important parts of some clients' lives that they wanted to discuss with their MHCWs. This required the MHCW to be able to distinguish between delusional disorders, conspiracy thinking, and other opinions and to respond adequately to these different phenomena. These are skills not universally trained in MHCW but crucial.[11]

Increasing waiting lists due to COVID-19-related psycho-

logical issues create increasing stress in working within mental health care. The shortage of MHCWs is just one of the reasons for long waiting lists. A recent study by Dubreuil *et al.*[12] revealed that negative emotions (such as stress) significantly affect work performance. Their findings suggested that strengths used in the workplace not only contribute to positive emotions but also reduce the occurrence of negative emotions, which in turn promote work performance. Our study revealed that the increased reliance on digital work contributed to a reduced sense of job satisfaction. An online survey showed that 4.2% of Dutch MHCWs consider quitting working in mental health.[4]

Consequences for the mental health care setting

Together, these developments can cause a possible overload of mental health treatment requests and an even greater increase in the number of patients on the waiting list, possibly leading to the loss of colleagues due to illness and burnout. Burnout complaints can occur as a result of various factors, such as the sustained stress from the COVID-19 pandemic the increasing influx of clients due to the COVID-19 pandemic, the expectation of increased workload and pressure within mental health care and reduced staff capacity. A recent study showed that the vacancy rate in mental health care is higher compared to other care, having increased by 18% compared to 2022.[13] The increase in workload and pressure creates a vicious cycle of further deterioration of the mental health of MHCW and turnover. Overall, 45% of MHCWs in this study reported that the workload was too high, attributed to regulatory and administrative burdens, staff shortages and working overtime. As mentioned earlier, Dubreuil *et al.*[12] reported that negative emotions significantly impact work performance. A similar development was observed among hospital staff. The larger influx of patients in combination with high absenteeism, burnout, and staff turnover poses immense pressure on hospital care. Similarly, mental health care faces a comparable risk of diminishing quality due to these challenges, potentially leading to a substantial departure of MHCWs. By the end of 2022, of the 7.5% sickness absence, 27% was work-related in a number of large mental health institutions in the Netherlands (www.azwinfo.nl, 2022).

Social support for MHCWs

Providing help and support to employees can prevent them from ending up in a negative spiral.[14] A recent study by Brugman *et al.*[15] showed that, if MHCWs make use of accessible social support, emotional exhaustion can be prevented. However, extra attention should be given to those less inclined to seek social support and those at higher risk of secondary traumatization. Despite the availability of social support, 25% of MHCWs still experience emotional exhaustion.

Social support includes, for example, promoting social support outside the work environment and maintaining social contacts. In addition, psychoeducation on mental self-care and prevention measures are important for overcoming emotional stress to prevent work-related dropouts while emphasizing self-management. Establishing a buddy system or prevention program within the workplace allows colleagues to support each other, enabling timely professional assistance for MHCWs. Reducing stigma can lower barriers to asking colleagues for help. This could include training programs to offer MHCW tools in which individuals learn to deal with conspiracy thinking.[11] Creating such support in a safe work environment requires clear organizational strategies at every level in the institution. A recent systematic review revealed three crucial factors that managers should pay attention to when retaining employees for care: job satisfaction, growth opportunities, and work-life balance.[16]

Organizations are responsible for promoting self-care measures among employees. Offering preventive training and workshops to help employees monitor their limits, manage stress and maintain a healthy work-life balance is crucial. Support can also be provided by offering flexible working hours and leave arrangements. In addition, mental health institutions must create a culture in which self-care is encouraged. In such a culture, employees can openly discuss their mental health without stigma.

Resilience of MHCWs

As mentioned earlier, a large proportion of MHCWs experience mental complaints. It is interesting to monitor professionals who do not experience these issues to the same extent. This group is characterized by a high degree of resilience. The resilience of an organization is largely determined by the resilience of its staff. This means that healthcare institutions must take responsibility to protect their MHCWs and make them resilient,[10] when they face new challenges. The Netherlands Institute of Psychologists also indicated that it would focus on the mental resilience of professionals by continuing to invest in professionals (through training, and creating social support in the workplace) and focusing on prevention, as mentioned in the Delta Plan for Mental Progress (https://mindplatform.nl).[16] The Trimbos Institute also acknowledges the risk of burnout among young MHCWs and offers tools for setting up such a policy in the guideline 'Preventing mental complaints among care workers', aimed at promoting the growth of resilience. For example, The Trimbos Institute recently published a guideline,[17] which offers tools to tackle a practice-oriented approach to mental problems in the workplace. It is also important to let MHCWs participate in decision-making. Regular inquiries about the health of MHCWs are also advised. As a practical solution, a walk-in consultation hour with a mental coach is mentioned. Offering training in which mental complaints and the influence on work pressure are the focus is also considered important, and a prevention program is experienced as helpful.

Discussion

These developments and forecasts of future capacity problems justify raising the alarm for mental health care professionals and the need to ensure support and interventions stimulating health promotion in the workplace. Institutions must provide support to their own MHCWs, as indicated by various studies and following the above-mentioned guidelines of The Trimbos Institute. Adaptive behavior guidelines: create support in the organization for openness about mental health; provide good general working conditions where mental health can be safely and openly discussed and where the workload is manageable; identify early signs of mental health concerns of MHCWs, allowing for timely discussions and interventions.

Job satisfaction, career development and work-life balance are three crucial factors in staff retention. While work-life balance is an individual matter, organizations should actively engage in ongoing discussions around this topic.

It is important not only to address existing complaints decisively, but also to focus on redesigning work structures to prevent the deterioration of mental health complaints. This responsibility extends from institutional choices to governmental policies. Government policies should prepare for future challenges, respond promptly to potential new pandemics and develop sustainable

strategies for MHCWs during crisis. Including mental health care in these plans seems to be a logical choice. This was endorsed by colleagues who responded strongly positively to the sharing of the above-mentioned research findings on social media with a call for the participation of MHCWs in government decisions (we received no less than 150,000 responses).

Future directions

Support for the mental health of MHCWs must be guaranteed to maintain sustainable employment and a well-functioning health care system. Promoting mental stability and resilience at an early stage in training and education is pivotal for preparing MHCWs and the health care system for ongoing challenges with respect to the continuity, availability and quality of mental health care. Future research should focus on interventions aimed at improving the mental health of MHCWs, enhancing their resilience and offering support to prevent and reduce burnout, sick leave and absenteeism.

Conclusion

Mental complaints such as stress and depression among MCHWs were substantial and increased during the COVID-19 pandemic. Post-pandemic, work-life balance seemed to be largely reversed, stabilizing mental health. Nevertheless, the prevalence of mental symptoms remains high among MHCWs. Furthermore, absenteeism rates increased, and people reported more absences post-pandemic than during the pandemic. MHCWs are struggling with long waiting lists, and at the same time, there are mental consequences of a pandemic that still have long-lasting effects and require considerable flexibility. Clients with permanent complaints due to the COVID-19 pandemic or as a result of infection with SARS-CoV-2 found their way to mental health care. This also applies to clients who develop mental complaints due to delayed somatic care, resulting in limitations in their well-being. Support for mental health care staff is needed to prevent further escalation.

Don't postpone! The mental health of MHCWs needs attention on the governmental agenda.

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Conflict of interest

The authors have no conflicts of interest to declare.

Author contributions

All authors contributed equally to the writing or revision of the article, and all authors approved the final version of the manuscript. Contributed to the study concept and design (AvdB and LdV), acquisition of the data (AvdB and LdV), assay performance and data analysis (AvdB and LdV), drafting of the manuscript (AvdB and LdV), and critical revision of the manuscript (AvdB and LdV).

Data sharing statement

Additional material consists of a digital report of the results of a survey among mental health staff on mental health during and after the COVID-19 pandemic and can be requested via the corresponding author.

Ethics statement

The MHCWs are permitted to use the survey data for research. Ethical approval for the survey studies was given by the appropriate institutional review committee: the scientific board of the Mental Healthcare Institute, GGz Breburg. The ethical guidelines of the Helsinki Declaration (as revised in 2013) were followed.

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