



# Prioritizing Health Care Worker Emotional Well-being Across the Country



# Acknowledgments

Mental Health America (MHA) was founded in 1909 and is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all; early identification and intervention for those at risk; integrated care, services, and supports for those who need them; with recovery as the goal.

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This project was made possible by the generous support of The Brave of Heart Fund.

The Brave of Heart Fund was founded by the Foundations of New York Life and Cigna and administered by E4E Relief.



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# Introduction

It's no secret that the impact of Covid-19 on frontline health care workers has been devastating. Health care workers face increased risks of coronavirus exposure and poor mental health outcomes. Health care workers have dealt with and are still experiencing stress, burnout, fatigue, grief, trauma, and anxiety related to the pandemic. We also know that hospitals and health systems are high stress workplaces, with staffing shortages and long hours.

Many supports are focused on doctors and nurses, not support workers, such as certified nursing assistants, or other professionals such as maintenance and food service workers. Additionally, many health care workers are wary of seeking help because they fear retaliation in licensing or credentialing, or because they know too many providers in their networks.

Thanks to a grant received from the Brave of Heart Fund to address the emotional well-being of health care workers, Mental Health America (MHA) worked with MHA affiliates across five states over the past 12 months to pilot several culturally responsive, evidence-based projects to serve health care workers and their families. Brave of Heart Fund was founded by the Foundations of New York Life and Cigna and administered by E4E Relief. Efforts were focused on promoting and supporting the emotional and mental well-being of frontline health care workers and health care workers in a supportive role and equip them to overcome challenges created or exacerbated by the COVID-19 pandemic.

Mental Health America is in a unique position because of its federated affiliate model. Each MHA affiliate offers different services and programs that are responsive to the needs of its respective communities. Because there were five different tactics chosen for five different populations in five different geographic regions, MHA was able to test several models of sustainable support for health care workers in each community.

The affiliates who participated in these pilot projects, the communities involved, and the focus area for each are:

1. Mental Health America of Los Angeles (MHALA), serving Los Angeles (LA) County, California, representing a major and diverse metropolitan area in the west, piloted Project Resilience, a resilience and skill-building program for hospital systems within LA County.
2. The Mental Health Association in New York State (MHANYS), serving all of New York State, representing a large state with urban, suburban, and rural areas, in the east, piloted the MHANYS CarePath™ Program, a life coaching program.
3. Mental Health America of Montana, serving all of Montana, representing rural, frontier, and tribal communities, in the middle of the country, piloted a warmline providing tribal and rural health care worker support.
4. Mental Health America of Greater Dallas, serving Dallas, Texas, representing a major and diverse metropolitan area in the South, piloted workplace wellness initiatives for hospitals.
5. Mental Health America in Montgomery, serving Montgomery County, Alabama, representing a mid-size city in the South, piloted a toolkit for support staff in health care settings.

Mental Health America conducted analysis to identify which programs were the most successful as compared to their original goal, which programs showed the strongest return on investment, which programs are the most replicable and scalable in communities across the country, and which programs had the largest impact on marginalized communities.

# Project Results

## MENTAL HEALTH AMERICA OF LOS ANGELES

### Program Goals and Results:

1. To recruit and provide the program to 200 health care workers from at least two hospitals. A total of 207 health care workers completed the program, representing 28 different medical facilities. The real-time training interventions, which were delivered via Zoom, included the following content areas: advantages of building up resiliency skills; the art of sleeping; the nature of trauma and how to cope with trauma; fostering healthy, supportive relationships; burnout and self-care; and coping skills with a focus on mindfulness and goal setting. Exercises that supported practice and mastery of content were included in the trainings.
2. To improve the overall mental health of frontline health care workers by increasing one's sense of control through resilience skills and well-being by 20% in two hospital systems, as measured by pre- and post-surveys. There was a 26% increase in participants feeling confident in their ability to bounce back, and a 54% increase in participants reporting confidence in their ability to increase their overall wellness.

### Return on Investment:

- Project Budget: \$100,000.00. Expenses were utilized for personnel costs and video curriculum development.
- Cost per participant:
  - Direct: \$483.09
  - Indirect: \$154.34

### Replicability and Scalability:

Plans are already underway to expand these trainings to additional populations of health care workers. New trainers are being trained in the delivery of the material, and additional funding for this expansion is being sought. The trainings were delivered during the latter year of the pandemic, which affected some of the content. Some future content and examples will be altered to make the training relevant to the specific time it is delivered.

This training program and content are available to be easily replicated and scaled up or down to meet each specific community's needs. The training video component of this project lends itself to wide distribution as well.

### Impact on Marginalized Communities:

This project served a total of 207 individuals living across Los Angeles County. The population identified as 89% female, 4% male, 0% transgender, 0% non-binary, and 6% indicating that they preferred not to answer a question about their gender.

The participants' ages ranged from 18 years to over 60 years old, with 72% between the ages of 25 and 45 years.

The vast majority of participants (74%) indicated they were Black, Indigenous, and people of color (BIPOC), with 19% indicating they were white/Caucasian, and 9% preferring not to answer.

In addition, 11% of our population identified as part of the LGBTQ+ community, 87% said that they did not, and 2% preferred not to answer.



# MENTAL HEALTH ASSOCIATION IN NEW YORK STATE

## Program Goals and Results:

1. To recruit and train 50 coaches to provide life coaching for health care workers and family members through the MHANYS CarePath™ training program. Seventy-two individuals were certified as MHANYS CarePath™ Coaches across New York State. Each coach worked with three health care workers and their families, totaling 676 people who were served through this program.

## Return on Investment:

- Project Budget: \$93,670.00 Expenses were utilized for personnel costs for MHANYS CarePath™ Program Coach training.
- Cost per participant:
  - Direct: \$1,301.00
  - Indirect: \$139.00

## Replicability and Scalability:

MHANYS CarePath™ program's scalability is due to the train the trainer model it employs. As Coaches populate the state and hopefully country, MHANYS CarePath™ Instructors can offer certification to select certified Coaches to become MHANYS CarePath™ Instructors and train and certify Coaches as needed. MHANYS CarePath™ programming is versatile and offers three options for providing CarePath™.

1. Original mode: 5-10- sessions throughout 90 days with an individual and their chosen family members or friends.
2. Support Group Format: 10 weeks of a support group format with several individuals managing recovery and their chosen family members or support groups for only peers managing behavioral health concerns.
3. Wellness Seminar: a five-week CarePath™ Seminar suitable for schools, faith communities, hospital settings, correctional settings, supportive housing settings, and centers supporting youth. Currently, the certification training offers credit clock hours for CASAC (Credentialed Alcoholism and Substance Abuse Counselors) NYS Peer Support Specialists, NYS Youth Peer Advocates, NYS Family Peer Specialists and NYS Peer Bridger's (working in Hospital settings).

## Impact on Marginalized Communities:

The CarePath™ Coaches trained and certified during this project represent 18 counties across New York State. These counties reflect urban, rural, and the most vulnerable counties with highest rates of poverty and immigrant and refugee families.

MHANYS CarePath™ Coaches trained and certified during this project came from employment that offers various forms of support for youth, adults and families across New York State. Certified CarePath™ Coaches provide services in the LGBTQ+ community, supportive housing, shelters, adult homes, faith community centers, immigrant and refugee families, veterans, adults with end stage diagnoses, justice impacted individuals, students in crisis, people experiencing dissociative identity disorders. This also included PTSD, domestic violence, sexual assault, crisis intervention services, addiction, foster care, reentry, employee assistance programming, traumatic brain injuries, intellectual and physical disabilities (including the deaf community).

This opportunity to become certified in the MHANYS CarePath™ model has extended their reach within those communities and offered workforce and professional development. Coaches are made up of, 15.2% male, 84.7% female, .01% Non-binary, and .097% represent the LGBTQ+ community. Other demographics include, 51.3% Caucasian, 31.9% Black-African American, 11% Hispanic-Latino, .1% Asian American- Pacific Islander, Native American-Alaskan .1% and .2% Multiracial.

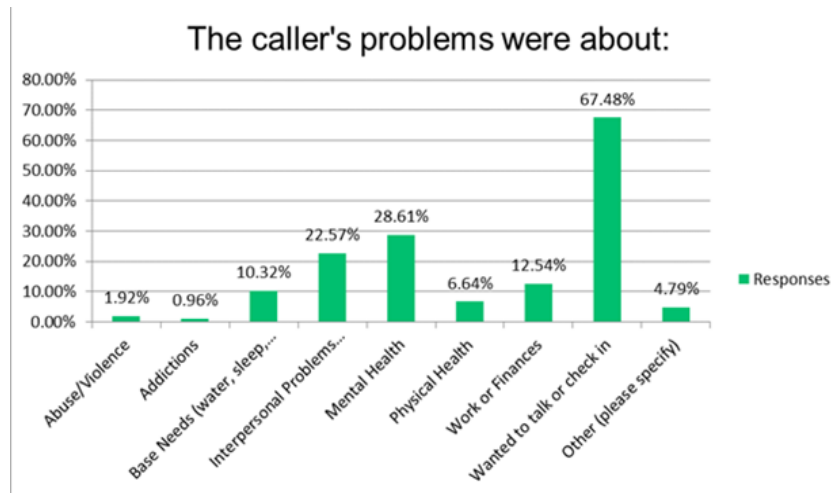
Primary language includes, 90.2% English, 4% Spanish-primary language, and 5.5% Primary language in Hindi, Gujarati, Polish, Russian, and Bosnian. Thirty-eight percent of individuals identified as peers (people with lived experience managing mental health), 23% identified as currently working as frontline health care workers, and .04% identified as veterans.

The ages of certified CarePath™ Coaches ranged from 20-71 years.

# MENTAL HEALTH AMERICA OF MONTANA

## Program Goals and Results:

1. The project goal was to reach at least 15% of Tribal and non-Tribal Health care workers across the state, which is 5,100. By completing just over 4,200 calls, 82% of this goal was reached.
2. To improve the mental well-being of callers, measured by a well-being screening survey completed at the end of each call. The survey provides information for the level of need of the caller, as well as helpful resources to help with stress, self-care, and burnout, influenced by the quality of the call.



This chart shows the topics the callers who identified as healthcare workers, either frontline or support staff, called the MHA of Montana Warmline. Responses captured in "Other" included burnout and frustration with work.

## Return on Investment:

- Project Budget: \$49,550.00, with additional funds supplemented by MHA of Montana. Expenses were utilized for personnel costs, including for tribal and health care responders.
- Cost per participant:
  - Direct: \$19.56
  - Indirect: \$6.25

## Replicability and Scalability:

MHA of MT had taken what was developed for their crisis line and warmline, and put those measures to work to reach out to the health care workers and Indigenous population across Montana. To successfully replicate this program and scale it up or down, it is important to work with partners within communities one is looking to serve, particularly in rural areas and with Indigenous populations. To build a successful warmline, it is recommended that an organization first seeks out funding and begins small, with limited hours, and works up to incorporating weekends and overnight hours.

## Impact on Marginalized Communities:

58% male, 40% female, and 2% other, not specified.

# MENTAL HEALTH AMERICA OF GREATER DALLAS

## Program Goals and Results:

1. To reach 25,000 urban and 5,000 rural health care workers through workplace wellness initiatives. In total, 30,456 people viewed, accessed, or listened to the Workplace Wellness information for frontline health care professionals. There was a higher percentage of rural health care workers who accessed this information and had a greater success rate than in urban settings.
2. To increase the comfort levels of individuals who attend the workshops to seek help by 30% in one year. This was measured through pre- and post-assessments, and this goal was met. Through MHA's Screening Program, 3,737 health care workers completed mental health screenings.

## Return on Investment:

- Project Budget: \$50,000.00 Expenses were utilized for personnel costs, training costs, and community outreach.
- Cost per participant:
  - Direct: \$14.48
  - Indirect: \$4.62

## Replicability and Scalability:

To replicate or scale this program up or down, the following are necessary: a full-time staff person who has established connections within the hospital, medical, and health field. There needs to be funding applied for marketing, and creating magnets for \$0.68 per magnet with information about the program and a QR code was successful. PowerPoint presentations on workplace wellness specific for medical and support staff in medical settings and handouts addressing subsections of workplace wellness will also be needed.

## Impact on Marginalized Communities:

All workplace wellness presentations were given to organizations that work with individuals who live at or below the poverty line or qualify for some state or federal assistance.

# MENTAL HEALTH AMERICA IN MONTGOMERY

## Program Goals and Results:

1. The organization measured success by the number of toolkits distributed, number of individuals reached by the toolkit, number of individuals linked to resources, and feedback from health care support staff, with the quality of education influencing the outcome. The first target was to develop a toolkit for health care support staff and provide education and training for over 300 individuals: 4,647 people in total received the toolkit, which was changed to a handbook, either in paper form or digitally; and 1,641 people were contacted in long-term care institutions throughout 11 counties. The manual was distributed and made available for download to people across the United States as a result of the newsletter mailing from Alliant Health that was sent to 21,986 people. Individuals and organizations were linked to 988 Mental Health and Suicide Lifeline, 211 and to Mental Health First Aider and Suicide Prevention QPR training. Individuals were provided with information on how to access behavioral health, talking to your doctor and resources for free counseling through the Emotional PPE Project.
  - 92.90% of the 845 survey respondents reported that the “It’s OK to Be Not OK” handbook increased their knowledge about mental health.
  - 89.67% of respondents reported the handbook helped them deal with their mental and emotional wellbeing.
  - 84.68% of respondents reported they spoke with their coworkers or family about the information in the handbook.
  - 69.12% of respondents reported contacting one or more of the resources listed in the handbook.

## Return on Investment:

- Project Budget: \$48,950.00. Expenses were utilized for personnel costs and toolkit printing and distribution.
- Cost per participant:
  - Direct: \$10.53
  - Indirect: \$3.37

## Replicability and Scalability:

The “BE OK” handbook can be shared with anyone through email or a visit to [BeOKToolkit.org](http://BeOKToolkit.org) or the MHA-M website or Facebook. There are also social media posts that any organization can share with their audience.

The “BE OK” handbook can be reproduced or copied by contacting MHA-M. The cost for printed copies could be negotiated with the printing company used by MHA-M and drop shipped to other organizations by the printing company. Organizations could update the resource page, choose a printing company of their choice, and give MHA-M and grantors the credit for the handbook. It would be prudent to update the resources that are local.

## Impact on Marginalized Communities:

21.46% of people who received the handbook live below the poverty level. Across the 11 counties where health care support staff work and live, 49.45% of the population identifies as non-white.





# Analysis

The anticipated number of people to serve through these pilots was 35,650. The total number of people served was 40,258, which is 12.93% above the original goal.

Mental Health America conducted analysis to identify which programs were the most successful as compared to their original goal, which programs showed the strongest return on investment, which programs are the most replicable and scalable in communities across the country, and which programs had the largest impact on marginalized communities.

Based on the outcomes and impact statements analyzed, MHA National determined:

MHA of Montgomery to have the highest return on investment, and with the most replicability and scalability that others across the country can adapt to their communities. The easy-to-read literacy level and the toolkit being in more than one medium are benefits for accessibility. In second place, MHA of Los Angeles has a higher initial direct and indirect cost, however, the materials are free to replicate, and the videos for each module have been created for anyone to view. This pilot has a high return on investment based on the pre- and post-training evaluations. In third place, MHA in New York State is next as this is a certified program that can easily be scaled up or down with assistance from the affiliate. This is a marketable program with low direct and indirect costs. Fourth, is MHA of Greater Dallas as this is a replicable workplace wellness initiative that can easily be adapted to another community. If another organization obtains the training materials and lessons learned from this pilot, they can begin mitigating challenges right away and adapt to a strategy that works best for them. The budget for workplace wellness training and promotional materials is also flexible based on existing partnerships and funding streams. Fifth, is MHA of Montana. There are higher direct and indirect costs associated with starting a warmline and promoting it to successfully serve health care workers. This warmline may have been more successful in a different geographic region with additional partnerships and funding.

## Next Steps

If you are interested in learning more about these pilot projects, including specific successes and challenges mitigated for each project, please visit the below links to view the recorded webinars and materials:

- <https://mhanational.org/events/health-care-worker-emotional-well-being-part-1>
- <https://mhanational.org/events/health-care-worker-emotional-well-being-part-2>

If you would like to be connected with one or more of these organizations, please contact Jenny Sanchez, Director of Grants Management and Projects, Mental Health America, at [jsanchez@mhanational.org](mailto:jsanchez@mhanational.org).