Role of the workplace in implementing mental health interventions for high-risk groups among the working age population after the COVID-19 pandemic

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The coronavirus disease 2019 (CO-VID-19) pandemic has caused an enormous psychological impact worldwide, especially among the most vulnerable, such as children and adolescents, the elderly, patients affected by the COVID-19 infection and individuals affected by psychiatric conditions before the onset of the pandemic. The psychological impact has been high for certain occupational categories, such as healthcare workers (HCWs), especially those who are working as frontline providers [1–5], social care professionals, workers involved in the production of essential goods, those in delivery and transportation and those ensuring the security and safety of the population. The burden of high stress has also affected people working from home who have been exposed to isolation and work–life imbalance issues as well as those who have lost their jobs, poor workers in the informal economy and inter-national migrant workers [6].

Despite the World Health Organization's urgent call for tailored and culturally sensitive mental health interventions, only a few countries have published specific psychological support intervention programmes for HCWs [7]. In the literature, scholars have focused their attention mainly on interventions that emphasise HCWs' mental health. However, to date, evidence of their effectiveness is scarce. Muller et al. [8] classified mental health interventions into those targeting organisational structures, those facilitating team/collegial support and those addressing individual complaints or strategies. A mixed-method systematic review of 16 studies on interventions for supporting mental health in frontline HCWs during previous disease outbreaks identified: 1) workplace interventions, such as training, structure and communication; 2) psychological support interventions, such as

counselling and psychology services; and 3) multifaceted interventions. However, quantitative and qualitative evidence from these studies is lacking [9].

Recommendations during the COVID-19 outbreak for frontline HCWs have considered the proper provision of information, psychosocial support (e.g. encouraging peer support, sharing and celebrating the success) and treatment for enhancing resilience; the monitoring of professionals' health status; and attention to the quality and quantity of tasks and responsibilities as well as to work patterns and working conditions [10].

A systematic review of 12 relevant studies described six early psychological interventions. Although the evidence base of these studies was limited, psychological first aid, eye movement desensitisation and reprocessing, and trauma risk management showed effectiveness across at least two studies, each among frontline workers. Promising results in single studies were found regarding resilience and coping in the healthcare community; resilience in work programmes; and the use of anticipate, plan and deter [11].

Tele-mental health services were also found to be particularly feasible and appropriate for the support of patients, family members and healthcare providers during the COVID-19 pandemic. The integration of this digital service with other technological innovations (e.g. mobile apps, virtual reality, big data and artificial intelligence) opens up new perspectives for the improvement of mental health assistance [12].

As shown by Zace [13] in a systematic review referring to SARS, Ebola, influenza AH1N1 and COVID-19, interventions addressing mental health issues in HCWs during pandemics/epidemics can be grouped into four categories: "1) informational support (training, guidelines, prevention programs); 2) instrumental support (personal protective equipment, protection protocols); 3) organizational support (manpower allocation, working hours, re-organization of facilities/ structures, provision of rest areas); 4) emotional and psychological support (psychoeducation and training, mental health support team, peer-support and counselling, therapy, digital platforms and tele-support)".

However, mental health interventions in the workplace present several relevant implications for occupational and public health stakeholders. HCWs are at high risk of substance abuse, suicide and post-traumatic stress disorder (PTSD) during the post-COVID-19 pandemic period, as mental health disorders, burnout syndrome and suicide risk among HCWs were considered critical issues for this occupational category even before the COVID-19 pandemic [14].

According to Buselli et al. [15], intervention can be implemented on an individual, organisational or societal level. Psychological support for HCWs should focus on organisational as well as individual characteristics, with a broader goal of maintaining an organisational culture of resilience. However, interventions in the workplace should not be limited to only HCWs, but they should consider all vulnerable groups of the population who are of working age. Indeed, workplaces represent

the best place to provide psychological support to the general population because many people spend most of their time in the workplace. Any psychological support should be preceded by mental health screening through mandatory health surveillance carried out by occupational physicians. This is possible because HCWs and social care professionals are subject to health surveillance for other risks and are exposed to several types of psychosocial risk factors (e.g. emotional demands, work-related stress, workplace violence) for their job [16].

In addition, workplaces represent the ideal arena for implementing mental health interventions aimed at promoting psychological resources and resilience and providing social and emotional support to susceptible workers, especially among high-risk people in the working age population [17]. This is possible through facultative workplace health promotion programmes. However, most of all, prevention and promotion interventions to reduce mental illness and social problems should be maintained over time to anticipate the effects of traumatic exposure by training workers in evidence-based anticipatory methods of coping with stressful events [18]. Indeed, previous studies have suggested that depression, anxiety disorders, substance abuse, increases in suicidal behaviours and PTSD commonly follow major economic crises or natural disasters [19, 20]. There is also evidence that HWCs who were directly involved in previous outbreaks of Severe acute respiratory syndrome and Middle East respiratory syndrome reported higher risks of developing psychiatric disorders following outbreaks and

for at least three years later [21]. Common mental health disorders, substance abuse, suicide and PTSD rates are expected to increase during the post-pandemic period as a result of the long-term effects of the pandemic, the restrictive measures, such as social distancing and quarantine, and the socioeconomic effects [22]. Therefore, the long-term psychological consequences of COVID-19 should be considered a major public health concern by policymakers, especially among the most vulnerable of the working age population.

For this reason, policymakers need to sustain the economic efforts of employers by funding their preventive and promotion activities. Furthermore, investments by governments are needed to strengthen healthcare systems worldwide. This is urgent to close the gap in preparedness of our healthcare systems and to tackle future pandemic and health emergencies more effectively. In this way, economic investments should deal with the human resources crisis and mismanagement in healthcare [23].

The workplace may represent an opportunity to integrate occupational health practices with public health activities [24, 25] and improve the health of the most vulnerable. However, further research is needed to understand their cost-effectiveness for individuals and organisations and their sustainability over time.

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