Healing in Health Care: Mental Health Promotion, Advocacy, and Voluntarism in Response to COVID-19

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The COVID-19 pandemic increased many known risk factors for mental health problems. In the context of overwhelmed health systems and resource and staffing shortages, the mental health needs of frontline health care workers (HCWs) gained attention as a major public health concern and a threat to high-quality care delivery. In response, mental health promotion initiatives were quickly developed to meet the demands of the public health crisis. Two years later, the context for psychotherapy has changed, especially as it pertains to the health care workforce. Particularly salient experiences—grief, burnout, moral injury, compassion fatigue, and racial trauma—have become routinely discussed as part of everyday clinical practice. Service programs have become more responsive to the needs, schedules, and identities of HCWs. In addition, mental health and other HCWs have contributed to advocacy and volunteer initiatives promoting health equity, culturally responsive care, and access to care across a range of settings. In this article, the authors review the benefits of these activities to individuals, organizations, and communities and summarize example programs. Many of these initiatives began in response to the acute public health crisis; however, engaging in these ways and spaces holds promise for increasing connection and prioritizing equity and structural change over the long term.

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The multifaceted challenges of the COVID-19 pandemic—fear, trauma, loss, disruption, and isolation—increased many known risk factors for mental health problems (1). Concurrently, social injustice, disparities, and inequities exacerbated health, mental health, economic, and social consequences (2). Health care workers (HCWs) experienced the stresses of the COVID-19 pandemic in the context of their personal lives, as well as in their professional roles and identities (3). Mental health needs of frontline HCWs, in the setting of overwhelmed health systems and resource and staffing shortages, have gained attention as a major public health concern and a threat to high-quality care delivery (4). In response, mental health promotion initiatives sprung up almost overnight to meet the demands of the public health crisis.

Two years later, the context for psychotherapy has changed, especially as it pertains to the health care workforce. Newly salient experiences—grief, burnout, moral injury, compassion fatigue, and racial trauma—have become routinely discussed as part of everyday clinical practice. Mental health providers have inhabited a unique role in responding to the mental health needs of the public, as well as of the health care workforce. This article summarizes the changed landscape following two pandemic years, focusing on HCW experiences and the benefits of mental health promotion, advocacy, and voluntarism to individuals, organizations, and communities. Many of these initiatives began in response to the acute crisis, yet are increasingly recognized as necessary measures for healing the health care workforce and systems over the long term.

ACKNOWLEDGMENT OF MENTAL HEALTH RISKS AND PROVISION OF SUPPORT

In the context of the COVID-19 pandemic, the challenges to HCW mental health were named and validated across health care settings and popular media. These challenges included potential threats to one's own health and contagion risk to coworkers and loved ones, lack of needed medical equipment and adequate personal protective equipment (PPE), and staffing shortages in the face of increased needs and financial pressures within health care systems (5). In addition, HCWs faced uncertainty about the magnitude, duration, and ultimate effects of the crisis and stress as systems prepared to treat large numbers of COVID-19 patients. Many likened these challenges to battlefield conditions and expressed concern for the front lines (6).

Providing mental health support to HCWs was identified as a priority, in order to mitigate negative psychological outcomes and to sustain the health care workforce. Numerous researchers and health systems developed new programs and structures geared toward increasing resilience and well-being of HCWs (7). Although the specific interventions varied, they had some shared characteristics. For example, these programs were typically offered within the workplace and were recommended by trusted leaders. In

addition, engagement was presented as prevention oriented and in alignment with participants' identities and values as HCWs (e.g., by using language such as "Mental Health PPE") (8). Mental health support was discussed as a priority that was supported by leaders and institutions and validated by the stressors of the COVID-19 pandemic. For example, New York's Mount Sinai Center for Stress, Resilience, and Personal Growth dedicated full-time mental health clinicians to caring for the health care workforce via a variety of channels, including a wellness app, resilience-promoting workshops, targeted outreach to clinical units, and trauma-informed mental health services. Many programs and health systems provided in-person routine rounds on mental health or group debriefing for key clinical units.

Often, components of these interventions were group based (9) and facilitated by mental health service providers. The opportunity to connect and acknowledge challenging experiences within teams was particularly important, because of the high volumes of very ill patients, isolation protocols, and high rates of death and serious disease. Palliative medicine settings provide everyday examples of the benefits of fostering community to process difficult experiences. They routinely protect structured time to express grief over dying patients, find meaning in the context of loss, and voice strengths and resiliency as well as personal vulnerability (10). The ability to be human, acknowledge pain and limits, and question one another and systems can provide support, facilitate intentional reflection, and promote sustainable practices. In the context of COVID-19, it has been acknowledged that the history of referring to individual HCWs as "heroes" may distract from valid collective challenges or reduce people's willingness to acknowledge limits or effectively seek help or assistance (4).

NAMING AND VALIDATING CHALLENGES TO HCWs' MENTAL HEALTH

Since the pandemic, HCWs have been able to acknowledge a number of experiences more freely. In addition to uncertainty, anxiety, trauma, and chronic stress (which have long been routinely discussed in mental health care), unique pandemic conditions led to collective processing and naming of particularly salient experiences, such as grief, moral injury, burnout, compassion fatigue, and racial trauma. These experiences are summarized briefly below, given their relevance for mental health providers in current practice.

Grief

Grief refers to a multitude of responses (e.g., affective, cognitive, physical, behavioral, and spiritual) that occur in the context of loss (11, 12). A failure to address grief can result in negative impacts on health. Complicated grief is a chronic and impairing form of grief that can arise when individuals remain in a state of indefinite grieving, prevented from processing the death (13). HCWs have long dealt with unprocessed grief and subsequent feelings of guilt and failure from patient deaths, feelings that often go unprocessed, denied, or minimized (14). These pre-existing experiences with grief have been compounded during the pandemic, in which grief has been endemic. The pandemic has brought about many losses, including loss of predictability, financial security, connectedness, health, safety, and autonomy (11). HCWs were faced with not only their own distress but also with treating and bearing witness to their patients' and colleagues' distress. These personal and professional losses, large surges in deaths, and difficult patient care decisions resulted in psychological and physical symptoms of grief. HCWs' exposure to significant suffering during the pandemic has been associated with increased distress, depression, anxiety, and insomnia (15).

Moral Injury

Moral injury occurs when people are forced to act against their moral code, either by taking action or by failing to take action. Typically, this type of injury is observed in military situations, when a person is exposed to trauma and has limited options for responding. During the pandemic, moral injury occurred among HCWs who were faced with decisions about how to prioritize insufficient resources (e.g., PPE, ventilators), resulting in poorer outcomes or deaths that might not have occurred under normal circumstances (16). Many HCWs expressed distress and concerns about their ability to provide their usual standard of care, because of high numbers of seriously ill patients and staffing shortages. In addition, HCWs observed very ill patients spending more time, and even dying, alone (17). It is known that being able to provide high-quality care is critical and necessary for professional satisfaction among physicians (18). Many HCWs cope with patients' severe illness and deaths by providing the best possible care and by attending to the humanity of each person. Emergency pandemic conditions affected workers' ability to do this, creating moral distress and injury because they could not do more to help the patients and their families.

Burnout and Compassion Fatigue

The Agency for Healthcare Research and Quality defines burnout as a long-term stress reaction that includes emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (19) that leads to high risk of lower quality care and increased errors (20). Burnout is associated with a combination of individual factors (age, education, and other demographic characteristics), psychological characteristics (e.g., poor self-esteem), expectations about one's job, and situational factors (16). Occupational, job, and organizational characteristics factor prominently into this equation. Even before the pandemic, up to 50% of U.S. physicians reported symptoms of professional burnout (21). The growing prevalence of burnout among health care personnel has gained attention as a potential threat to health care quality and patient safety (22). Even before the pandemic, health systems were being encouraged to consider

burnout a systems problem and not an individual problem (21). Team identification, or the feeling that one is a part of a team, has been found to protect against stress and burnout in times of prolonged stress. This finding, initially discovered in military contexts, was replicated during COVID-19 (23).

Relatedly, compassion fatigue can be understood as emotional, physical, and spiritual exhaustion secondary to witnessing the problems and distress of others. Compassion fatigue is frequently encountered when working with traumatized individuals (24). Whereas burnout refers to the interaction between an individual and their work environment, compassion fatigue refers to the psychological processes within the individual (25). Compassion fatigue may be a pathway to burnout, because of the increasing difficulty of helping in ways that yield a sense of purpose. Similar to burnout, compassion fatigue is associated with absenteeism and turnover, as well as behaviors including isolation from others, increased drinking or overeating, substance use, and other maladaptive coping measures (20). Compassion fatigue is common in disasters, when the need for care can exceed the ability to provide it; empathy can be depleted when high volume, emotionally challenging caseloads are seen without adequate time to recharge or practice self-care. HCWs may experience distress when they observe limits in their ability to feel or respond with compassion, because these experiences are seen as threatening to individuals' sense of mission and long-term career satisfaction (26). Compassion fatigue is especially common in environments that care for large numbers of people for whom the outcome is dire, such as during the COVID-19 pandemic, when so many people required emergency care and admission to intensive care units (20).

Racial Trauma

The COVID-19 pandemic highlighted the stark and long-standing racial-ethnic disparities experienced by people of color that exist even when insurance status, income, age, and severity of conditions are comparable (27). The pandemic has also illustrated the extent of the mental health impacts of racial trauma on HCWs. Racial trauma has emerged as a chief complaint among staff at all levels of health care (28). For example, Asian American providers have experienced increased discrimination in the form of statements about blame for the pandemic, threats to their safety, racial epithets, and treatment refusal—all amid the significant stressors associated with overwhelmed health systems (16). Racial trauma, caused by individual, cultural, and structural racism, and experienced by Black, Indigenous, and people of color (BIPOC), has been exacerbated during the pandemic, significantly affecting mental health (29). It has been increasingly acknowledged that HCW trainees are especially vulnerable and may benefit from support in their patient care roles; managers, supervisors, and educators can build skills in listening and assist in ensuring safety as well as shape cultures that are safe and trusting (28). Tools (30) have been developed to acknowledge and help manage the heightened stress of racial trauma. Many HCWs have voiced their experiences as a way to validate others' experiences and to highlight the needs and specific directions for change (31).

RESPONSES TO PANDEMIC-RELATED CHALLENGES

In response to these challenges to mental health, and broad agreement that HCW mental health requires active maintenance and support, tailored mental health and resilience promotion programs have become commonplace. A recent scoping review (7) has summarized 41 such initiatives. In addition to new and more responsive mental health care programs for HCWs, increasing numbers of people also have come together to engage in advocacy and volunteer opportunities related to mental health and health equity. These initiatives have been a significant source of innovation and learning during the past two pandemic years. Later, we provide examples of each type of engagement.

Initiatives Responsive to the Mental Health Needs of HCWs

New programs have acknowledged and reduced several practical barriers (e.g., scheduling processes, hours of operation) that had historically limited HCWs' ability to access or benefit from traditional mental health services. Many mental health clinics operate only during business hours, when many in health care have limited availability to attend, and rely on patients' availability to answer phone calls to provide intake information, determine insurance coverage, and schedule initial appointments. Appointments are typically scheduled weeks ahead and rescheduling is burdensome, requiring additional phone calls, lengthy hold times, and phone tag. This type of service model was recognized as being incompatible with a COVID-19 health care workforce that has changing schedules, nontraditional hours, and PPE restricting access to cellular phones in the midst of pandemic care. Additionally, given the stresses of the pandemic, it became clear that HCWs needed access to more immediate, scalable, short-term support options. It was recognized that mental health services must be accessed quickly, deployed flexibly, and utilize more (and more efficient) channels between existing services. One such example is shown in Box 1.

Advocacy Initiatives

The pandemic highlighted existing racial, ethnic, and economic disparities, inequities in access to care, and systems and power structures that maintain these insidious societal problems. The interactions between the pandemic, structural racism, and mental health inequities created syndemic conditions (2) and turned the attention of many toward policy interventions that could address the systemic and structural barriers that have created inequities (32). The need for advocacy at the local, state, and federal levels was

BOX 1. Example of a mental health care program for HCWs

The Care for COVID-19 Responders program, offered through Emory University's Department of Psychiatry, aimed to create a mental health service that provided immediate support, assessed needs, and facilitated rapid access to psychiatric services for frontline HCWs. This system-wide, free, virtual mental health support program was staffed by a broad base of faculty and trainee volunteers in the university's psychiatry department and was launched within 5 days in March 2020.

The format was virtual, with appointments available between 6 a.m. and midnight, 7 days per week. Two levels of service were available: support calls and clinical services (psychotherapy and medication management). Support calls were free, 30-minute, virtual encounters designed to validate stressors HCWs face, provide emotional support, identify coping strategies, and assess need for additional psychiatric services. Those who could benefit from additional clinical services were immediately scheduled as soon as the next day. These clinical services were in-network for the health care system's employee health plan, eliminating the risk of surprise bills for clients.

HCWs could use the program in several ways: they could access support calls on an as-needed basis, schedule a series of support calls with the same provider for short-term support, or access in-house therapy and/or medication management services for longer-term care and follow-up. These various access models enabled tailoring of level, frequency, and duration of care based on the HCW's needs and schedule. To implement the program outlined above and to provide easy access to care, Acuity Scheduling (acuityscheduling.com), a live-scheduling online platform, was used. This platform provided real-time, 24/7 scheduling access with integrated appointment confirmations and Zoom links, automated matching of HCW to provider, and eliminated phone tag or scheduling delays. HCWs could leave the night shift at 7 a.m. and, within minutes, schedule a support call for later that day, or they could book an appointment at midnight at the end of a shift.

Caller Characteristics

A majority of callers (61%) identified as direct clinical care providers: physicians, advanced practice providers, nurses, and medical and nursing technicians. Callers with primary laboratory-based or administrative positions accounted for 24% of calls. Callers were based in more than 35 clinical sites and programs. Gender was recorded indirectly from pronouns in the support call notes and indicated that most callers identified as female (86%).

Utilization

In the first month of the program, 103 HCWs used the service for a total of 203 completed encounters. Sixty HCWs (60%) used support calls only, and 43 HCWs (40%) used additional clinical services. Following the initial surge of COVID-19, call volumes decreased. By August 1, 2020, a total of 353 encounters had been completed (186 support calls, 64 therapy appointments, 47 medication management appointments, and 56 group therapy appointments).

Usage Patterns

After-hours availability was well used, with 51.91% of all support calls occurring outside typical clinic hours (i.e., 5 p.m.–12 a.m., 6–9 a.m., and weekends). For clinical services, 42.4% of appointments occurred outside typical clinic hours. The most highly utilized call times across all services were (in order): 5 p.m., 8 p.m., 1 p.m., 10 a.m., 2 p.m., and 5:30 p.m.

Appointment Timing

Total time between accessing the scheduling site to receiving an appointment confirmation e-mail was less than 2 minutes. Access to scheduling follow-up clinical services was provided immediately following initial support calls. Time between completing an initial support call and a clinical service appointment was typically less than 48 hours.

Cancellations and Rescheduling

The cancellation rate was 17.5%, and the no-show rate was 5%. Of the cancellations, 43% (N=43) were rescheduled, more than half in a time slot within the next 24 hours. This ability to quickly and easily reschedule is not possible within most clinic systems.

Summary

This clinical service model was designed to meet the mental health and scheduling needs of frontline HCWs by leveraging a flexible online scheduling platform and extended hours. Utilization data suggested that offering both support calls and clinical services was beneficial. The usage patterns data highlighted the importance of after-hours availability for support calls, easy rescheduling, and rapid access to clinical services.

clear, and it became increasingly recognized that those with medical and behavioral health expertise were equipped to engage in advocacy. New interprofessional teams and partnerships were formed (9) to advocate for changes in clinical care delivery and public health policy, ensure access to culturally responsive health care, and design programs to address social determinants of health (33). Increasing numbers of medical and mental health professionals began to apply their expertise and influence in concrete ways to advance the health and well-being of individual patients, understand the communities and social factors that influence patients' health, confront bias in practice, and develop processes to promote health equity (34).

Large professional societies in medicine and mental health have taken on new advocacy efforts, in response to the consequences of the pandemic, and have provided new ways for people to stay informed and get involved. For example, the American Psychological Association joined with like-minded groups to build coalitions of scientific, health provider, and consumer groups to share information and

strengthen policy support. The American Psychiatric Association offers new opportunities, through online courses and advocacy alerts regarding current legislation and important issues, to learn how to take action. In the education domain, curricula on social justice advocacy have been developed to build these competencies among future generations of professionals (35). At the local level, many workplaces and academic settings have created teams to advocate for core values, such as equality, social justice, human rights, and access to care. One example is described in Box 2 (36).

Voluntarism

A wave of solidarity has been described across the world during COVID-19, in which volunteers have heeded calls from their communities to assist vulnerable groups, provide essential services, and support frontline workers. Tens of thousands of new volunteers assisted elderly persons, supported schoolchildren, and enabled new and necessary food bank initiatives (37). Mental health care and other HCWs volunteered during COVID-19 by educating the public, staffing testing and vaccination sites, providing services in underserved and free clinics, and supporting frontline providers (38). An example of a volunteer program is described in Box 3.

MOVING FORWARD DIFFERENTLY

New models for mental health care continue to proliferate; however, the lack of equitable mental health access remains a primary and central problem that cannot be addressed within the health system alone. The need for coordinated ongoing response and supportive policy, including expanded insurance coverage of mental health services, integration within primary care and general medical health settings, and connection with community support, has been articulated (39). In support of this need, HCWs and mental health providers have entered new spaces and roles, involved in prevention and mental health promotion, advocacy, voluntarism, and other pursuits.

The impacts of these initiatives are significant and have been cited among the victories of the dark pandemic times, but it also bears mention that there are benefits to those who participate, and to the settings and communities that they reside within. These types of engagement are healing and sustaining and can serve as important sources of meaning, connection, and purpose. These ways of engaging will continue to be critical as the complex interconnected societal problems associated with mental health and health care receive new types of attention and investment.

BENEFITS OF COVID-ERA INNOVATION TO INDIVIDUALS, ORGANIZATIONS, AND COMMUNITIES

COVID-19 represented a new and extraordinary set of conditions that intensified difficulties experienced by HCWs. During the pandemic, acknowledging the risks to mental health inherent in health care, providing support for HCW well-being, and acknowledging that existing models did not serve workers' practical needs were important steps forward. Creating additional opportunities for support and connection was both essential and overdue. However, the crisis responses summarized previously align with literature focused on addressing longstanding problems with professional burnout, stress, and systems-level challenges in health care settings. It is useful to connect lessons learned in response to COVID-19 with these larger frameworks, as well as the well-characterized benefits of engagement, advocacy, and voluntarism.

It is significant, but not surprising, that mental health promotion, advocacy, and voluntarism opportunities during

BOX 2. Example of mental health advocacy

The Atlanta Behavioral Health Advocates (ABHA) is a group of behavioral health professionals who engage in social justice advocacy for the behavioral health needs of individuals and communities experiencing oppression, discrimination, and barriers to health care. Core aims of the group include communicating to community members and legislators about how to better meet behavioral health needs, advocating for partnerships with community members, and providing clinical and consultation services (36). One recent initiative involved supporting a bipartisan state-level mental health bill. ABHA members, including trainees and mental health professionals across a range of disciplines and settings, consulted with policy experts and lobbyists to learn effective ways to engage with legislators and to understand the history of previous mental health bills in the state. The group partnered with the Carter Center (a local organization committed to human rights) and the Georgia Parity Collaborative to advocate for and track the bill through the House and Senate and to collaborate on needs and next steps at each stage. ABHA's Legislative Subcommittee reviewed the full bill. ABHA collectively wrote letters to representatives on the relevant committees in support of specific language in key aspects of the bill (e.g., mental health parity). They created a template that individuals (and particularly constituents) could use to contact their state representatives to support the bill. ABHA also shared informative sources with constituents and stakeholders, so that individuals and families could better understand the legislative process and how they could effectively engage at each stage, including opportunities to assemble at the Capitol. In doing so, ABHA members became more familiar with the state legislative process, developed community partnerships, and served as a mental health resource to those involved in policy. The Mental Health Parity Act was passed in the House and Senate and then was given to the governor to sign.

BOX 3. Example of a volunteer group in mental health

Caring Communities at Emory University (9) is an interprofessional group of mental health professionals and trainees, including psychologists, psychiatrists, and clinical social workers who mobilized in the face of COVID-19 to provide communities with support, guidance, and compassion. Caring Communities recognized that alongside the viral pandemic, there were emotional and psychological challenges associated with this crisis that could be addressed together. Caring Communities provided support groups, debriefings on key clinical units, tip sheets, wellness activities, education for health care professionals and the public, and other interventions. By engaging in these activities, members gained experience using clinical skills in new contexts and learned new crisis response, program development, and/or implementation skills that were responsive to real-world conditions. Those who provided support to frontline HCWs and other communities reported gratitude for the ability to contribute in concrete ways by using their skills in behavioral health interventions and by collaborating across disciplines and work settings. Endeavors such as these provide the opportunity for people to connect and contribute ideas, time, and effort for a greater good.

the pandemic incorporate many of the known prerequisites for restoring meaning and joy in work and increasing fairness and equity (40). Such investments have far-reaching and tangible benefits to individuals, organizations, and care outcomes. Successfully increasing joy and engagement among the health care workforce is associated with lower burnout, fewer medical errors, improved patient experience, less waste, higher customer satisfaction, and improved productivity (41, 42). Joyful, productive, and engaged people report feeling physically and psychologically safe, experience and appreciate the meaning and purpose of their work, experience camaraderie and connection at work, have some autonomy in their roles, and perceive their work life to be equitable.

The Institute for Healthcare Improvement (IHI) describes several steps for increasing joy in work (43), each of which are evident in the COVID-era initiatives described above. The IHI's first step begins by asking what matters most; work is connected to mission and shared values, and progress and impact are monitored. This connection to mission and core values was a common feature of the many responses to COVID-19: interventions were focused on equity, access to mental health services, and connection and support between colleagues. The effects of aligning one's work with one's core values are significant. For example, a Henry Ford Health System survey identified that employees involved in health care equity work were seven times more engaged than other employees (43). Because improved engagement is associated with improved performance, professional productivity, and lower turnover and costs to organizations (44), maintaining mission-driven COVID-era innovation efforts has been recommended, particularly those related to HCW mental health (1).

IHI's second step to increasing joy in work is to identify systems, processes, issues, or circumstances that impede professional, social, and psychological well-being. Systems are not always willing to do this, but during the COVID-19 pandemic, the dialogue about promoting mental health and health equity became central. The initiatives described previously demonstrated the use of disruptive or creative methods (many using newer technologies) to target or circumvent historical problems and unworkable processes. During the pandemic, waiting for slower or more iterative change or improvement was not feasible; the successes and lessons learned from more high-risk and high-impact experiments have altered conditions moving forward and have created a precedent for rapid innovation.

As a third step, IHI cites making joy in work a shared responsibility implemented by teams composed of individuals from all levels within organizations. Broad and inclusive engagement, with reduced hierarchy and increased trainee and junior employee involvement, were hallmarks of many COVID-era innovations. These innovations improved workplace health in the short term and hold promise for increasing training opportunities in advocacy, program development, voluntarism, and other types of innovation (9). Finally, the IHI's fourth step uses improvement science to quantify progress toward goals and to illustrate impacts of new initiatives to justify continued support. Significant COVID-era successes in this area have been reported. For example, one academic medical center described a five-step process for fostering and measuring physician well-being and regaining purpose, in which recommendations for change were aligned with institutional goals, and progress was monitored by validated evaluation metrics enabling national comparison. The intervention led to improvement in faculty burnout scores and overall satisfaction scores and in leaders meeting incentivized goals (45).

Responses to the COVID-19 pandemic have replicated the well-characterized benefits of voluntarism. Among elderly samples, active volunteers have 63% lower mortality (adjusted for age and gender) (46), and having a strong connection with meaning and purpose is similarly protective (47). Volunteering is associated with higher well-being cross-sectionally and with positive change in well-being over time (48). During past crises, benefits of volunteer involvement on subjective well-being have been observed among vulnerable populations (e.g., refugee youths) and attributed to the direct connection with those receiving assistance, opportunities for learning practical and leadership skills, and experiencing a sense of belonging (49). Even among those whose roles involve responding to

distress (e.g., crisis line volunteers), many report satisfaction and gratification from their work (50). Engaging locally appears especially beneficial; volunteering with those who are spatially or socially close may be experienced more concretely (51). The years 2020–2022 have been characterized by social distancing protocols and experiences of isolation; in this context, experiences of connection, belonging, and purpose may be particularly protective. Helping others can help regulate one's own emotions, providing a sense of control and buffering the effects of stress on the body (reducing the association between stressful life events and mortality) (52). Before COVID-19, loneliness had already been labeled a behavioral epidemic and linked to societal factors (53), with effects of social isolation comparable with smoking and obesity (54). Similar to HCW mental health efforts and advocacy, these efforts will become no less important in the future.

CONCLUSIONS

Innovations in mental health support for HCWs, advocacy, and voluntarism occurred in response to the extraordinary challenges presented by the COVID-19 pandemic and the associated disparities and inequities it highlighted. This innovation reflects a welcome and novel shift toward recognition of the importance of mental health and increased willingness to prioritize and invest in the well-being of the health care workforce. New programs and approaches increasingly acknowledge HCWs' unique needs, schedules, and identities.

Mental health and other HCWs have also contributed to advocacy and volunteer initiatives across a range of settings. The public health emergency has highlighted, but also invigorated, the fight against complex systemic problems that have plagued health care and community policy for generations. A new multigenerational, diverse group of advocates and volunteers has gained valuable experience and has observed that rapid transformation and broad, inclusive engagement are possible. Through involvement in these new, varied spaces came accelerated learning and development and additions to training curriculums that include more exposure to policy and social justice advocacy. Importantly, engaging in these ways has been healing. New initiatives have facilitated connection with others with shared values on access and equity and have fostered innovation with rare immediacy, creativity, and speed.

There is widespread agreement that COVID-19 has been not only a crisis but also an opportunity to improve health and mental health services. It has also been an opportunity to prioritize equity and structural change. We do not yet know all the forms these changes will take, but the healing of COVID-era activities has illuminated a few: acknowledging challenges in health care and supporting individuals; being honest about what depletes us and what sustains us; connecting across settings, disciplines, and typical divides; and building broad engagement as a critical resource for changing our spaces.

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