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Perspective Piece

Psychological distress among healthcare workers post COVID-19 pandemic: from the resilience of individuals to healthcare systems

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Abstract

Since the emergence of the COVID-19 pandemic, there has been increased interest in identifying ways of protecting the mental well-being of healthcare workers (HCWs). Much of this has been directed towards promoting and enhancing the resilience of those deemed as frontline workers. Based on a review of the extant literature, this paper seeks to problematise aspects of how 'frontline work' and 'resilience' are currently conceptualised. Firstly, frontline work is arbitrarily defined and often narrowly focused on acute, hospital-based settings, leading to the needs of HCWs in other sectors of the healthcare system being overlooked. Secondly, dominant narratives are often underpinned by a reductionist understanding of the concept of resilience, whereby solutions are built around addressing the perceived deficiencies of (frontline) HCWs rather than the structural antecedents of distress. The paper concludes by considering what interventions are appropriate to minimise the risk of burnout across all sectors of the healthcare system in a post-pandemic environment.

Key words: COVID-19; healthcare workers; mental health

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Introduction

Healthcare workers (HCWs) experience high rates of mental ill-health related to excessive workloads, working in emotionally charged environments, and stigma against care-seeking (Woo *et al.* 2020). Indeed, significant levels of burnout among clinical and non-clinical staff in Ireland and elsewhere have been documented, prompting calls for immediate action to improve the working environment of HCWs (Chernoff *et al.* 2019; Hayes *et al.* 2019; McNicholas *et al.* 2020; Doody *et al.* 2021). Since the emergence of COVID-19 as a global public health threat, interest within academia and policymakers in identifying ways to enhance the resilience of HCWs, particularly among those deemed to be working on the frontline, has intensified. Definitions of what is meant by frontline have varied. In its broadest sense, a frontline worker can be considered an individual who provides their labour in person rather than from home and, therefore, is at increased risk of contracting COVID-19 (Blau *et al.* 2021). In a healthcare context, this includes anyone in direct contact with people who use healthcare services and laboratory staff or pathology staff (HSE, 2021).

However, the vast majority of national and international scholarship on the psychological well-being of frontline HCWs has focused on acute hospital settings such as accident and emergency departments, critical care units, and COVID-19 testing facilities and wards (Barello *et al.* 2020; Carmassi *et al.* 2020; Flynn *et al.* 2020; Serrano-Ripoll *et al.* 2020; Spoorthy *et al.* 2020; Sritharan *et al.* 2020; Creese *et al.* 2021). There are compelling reasons behind this focus on the psychological needs of HCWs working in acute hospital-based settings. For example, it has been well documented that the seismic increase in demand for healthcare at the initial stages of the pandemic was borne mainly by HCWs in hospital settings. Studies have shown that the threat of exposure to the virus, the possibility of infecting colleagues and family members, as well as the stigma of being a potential carrier, led to an increase in mental distress among HCWs in these settings (Heath *et al.* 2020; Pollock *et al.* 2020; Serrano-Ripoll *et al.* 2020). Furthermore, many have been forced to make decisions that violate their ethical code, such as deciding which patients to treat and which to not (Williamson *et al.* 2020), while others have been redeployed to new roles and teams, often without adequate training (Khajuria *et al.* 2021).

Beyond acute hospital-based settings

Nonetheless, the focus on the psychological challenges of working in acute hospital-based settings during the COVID-19 outbreak has meant that the well-being of HCWs in other sectors of healthcare, such as those situated in primary and community care settings, has been relatively overlooked in the literature (Billings *et al.* 2021). This lacuna may partly stem from a perception that there were fewer demands on both primary and community care settings relative

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to secondary care, at least in the initial stages of the pandemic. In addition, there may also exist a perception that because many community HCWs were able to switch to remote forms of care provision they therefore avoided some of the psychological burdens typically associated with frontline work. However, HCWs in community settings continued to work directly with healthcare users and the general public, thus experiencing similar risks to those working in acute hospital-based settings. Moreover, numerous quantitative studies surveying HCWs' well-being across a wide range of jurisdictions during pandemic situations have shown that those deemed to be working in non-frontline settings often experience levels of distress comparable to their frontline colleagues. For example, Conti *et al.* (2020) carried out a survey-based study to explore the mental health status and psychological care needs of 933 HCWs in Italy during the first COVID-19 outbreak. The study sought to directly compare the incidence of psychopathological symptomatology among frontline workers (defined as those directly involved in the clinical management of healthcare users with suspected or confirmed COVID-19) to those in the secondline. Contrary to their initial hypothesis, working directly with COVID-19 infected healthcare users did not induce more psychopathological symptomatology compared to those not working with COVID-19 healthcare users. A study in China revealed no differences in depressive symptoms among those on the frontline (defined as contact with confirmed COVID-19 infections) compared to those on the secondline (Peng *et al.* 2021). In a similar study in Oman, frontline workers (defined as those directly engaged in clinical activities such as diagnosing, treating or providing nursing care to healthcare users with elevated temperatures or healthcare users with confirmed COVID-19 infection) were found to have higher levels of anxiety and insomnia; however, levels of depression in both frontline and non-frontline HCWs were found to be the same (Alshekaili *et al.* 2020). In other studies, it has been suggested that firstline exposure may, in some circumstances, be protective. For example, research carried out in China by Li *et al.* (2020) found that vicarious traumatisation was lower among frontline nurses (defined as the process of providing care for healthcare users with COVID-19) compared to non-frontline nurses. The authors speculate that one reason for this may be that frontline workers in China possess more training and hands-on experience in dealing with disaster situations and therefore were more likely to be psychologically prepared for the impacts of COVID-19.

Lived experiences of frontline and non-frontline workers

This emerging body of evidence indicates that the experiences of HCWs, regardless of frontline or non-frontline status, are unlikely to be 'universal, unidirectional, nor unidimensional' (Kinsella *et al.* 2022). Indeed, qualitative research both in the United Kingdom (U.K.) and Ireland is helping to elucidate the complexities and nuances of frontline HCWs' lived experiences during the COVID-19 response. These studies reveal that the complexities of working on the frontline involve both struggle and reward (Kinsella *et al.* 2022). For example, in a recent study that examined the experiences of working on the frontline across a variety of occupations in the UK and Ireland, Kinsella *et al.* (2022) reported that the psychological struggles of frontline work were often counterbalanced by the more rewarding and enriching aspects of being involved in the COVID-19 response which included 'empowerment and self-efficacy derived from knowing that you have a role to play and that there is something that you can actually do to help'. Furthermore, Kinsella *et al.* (2022) also noted signs of positive growth among their participants which included 'gratitude, savouring, religiosity, changed priorities and enhanced relationships with others' (Kinsella *et al.* 2022). These findings align with a recently published study that reported pandemic-related post-traumatic growth among frontline workers in Canada (Feingold *et al.* 2022).

There have been fewer qualitative studies on the experiences of HCWs deemed to be working in non-frontline settings. However, a small number of studies have begun to highlight the significant challenges faced by HCWs in adapting to new care models and expanded aspects of clinical care provision whilst transitioning to remote forms of care. For example, in a study carried out in the U.K. by Billings *et al.* (2021), mental health professionals reported that providing emotional support to their NHS colleagues whilst working remotely was often experienced as a significant stressor, with many finding it difficult to dissociate their work from home life. In another study in the U.K., non-frontline staff reported guilt for making less of a contribution to the COVID-19 response (Wilson & Bunn, 2021). Thus the experience of providing usual care but deemed 'non-frontline' may give rise to unique stressors that could impact on well-being. Furthermore, it is unknown to what extent the rewarding and enriching aspects of the COVID-19 response reported by Kinsella *et al.* (2022) were also experienced among those deemed non-frontline.

In summary, it is clear that there was a significant degree of psychological strain experienced by HCWs across the healthcare system during the COVID-19 pandemic. For some, the psychological distress experienced may be short-term and should not be pathologised (Greene *et al.* 2021). Indeed, there is a sense that many HCWs may derive meaning and satisfaction from the COVID-19 response despite (or perhaps even because of) the severe emotional and cognitive demands it entailed (Billings *et al.* 2021; Kinsella *et al.* 2022). However, for others, there is a risk that this distress may become chronic and deleterious. Therefore experiences of distress need to be considered from an individual perspective and across time.

Moreover, the evidence presented above also suggests that, when applied across different sectors, the binary categorisation of HCWs into 'frontline' and 'non-frontline' becomes increasingly tenuous and potentially unhelpful in identifying those at risk of chronic distress and longer-term burnout. This is particularly the case in community and primary care, where many HCWs had direct contact with healthcare users but also provided remote forms of care during the pandemic. Seen in this context, the line between frontline and non-frontline becomes somewhat blurred. Moreover, as we transition out of the pandemic, it is widely anticipated that there will be a surge of referrals to primary and community care in the medium- and longer-term (Lyne *et al.* 2020). In Ireland, there is expected to be a significant increase in demand for primary and community care services due to non-COVID healthcare issues, such as mental health, not being sufficiently managed during the pandemic crisis (O'Connor *et al.* 2021).

Thus, there is now, more than ever, an urgent need to identify ways of protecting the well-being of individual HCWs in all sectors of the healthcare system as a means to prevent burnout and ensure the sustainability of health services in the post-pandemic environment.

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Alleviating the mental health burden of HCWs: what are the next steps?

Given the issues highlighted above, it is worth reflecting on what provisions are being put in place to support the mental well-being of HCWs in an Irish context. In the document, 'HSE Psychosocial Response to the COVID-19 Pandemic', (HSE, 2021) a commitment is made to 'sustain and develop psychosocial awareness and expertise by building on existing psychosocial materials and initiatives to address the emerging training and educational needs of healthcare staff'. In this regard, a range of 'key supporting actions' are identified to increase the resilience of HCWs, including 'psychological first-aid', a 'workplace wellness app', 'psychosocial peer support', and 'self-help tools such as CBT-based modules'. While the increased interest in the mental well-being of healthcare professionals is to be welcomed, a growing body of literature has highlighted some of the more problematic aspects of relying on individual-level interventions alone to improve the mental well-being of HCWs. A Cochrane review has shown limited evidence for the effectiveness of interventions aimed at increasing HCWs resilience during COVID-19 and comparable pandemics (Pollock *et al.* 2020). There is also an emerging body of qualitative evidence providing clues as to why such well-being programmes may not have worked as intended. For example, Billings *et al.* (2021) elucidated the lived experiences of NHS health and social care workers during the COVID-19 pandemic and the specific forms of psychosocial support they perceived to be valuable. The study showed that while participants were in general positively disposed towards employee workplace initiatives, many participants did not know how to access such services, while others reported that the intensity or timing of their work schedule prevented them from attending. Furthermore, many cited stigma and fears about being perceived as weak by colleagues as a key barrier to uptake.

In another U.K. based study, Vera San Juan *et al.* (2020) examined HCWs' perceptions of clinical guidelines on workplace well-being during the COVID-19 outbreak. As a whole, the guidelines focused on well-being at an individual-level, while HCWs placed greater emphasis on structural conditions at work, such as understaffing and time-off. These studies align with a significant body of literature that has pointed to the crucial role that social and organisational dynamics play in the onset of psychological distress both prior to and during COVID-19 (Montgomery *et al.* 2019, 2021; De Kock *et al.* 2021; Panagioti *et al.* 2017; Shanafelt & Noseworthy, 2017; Regenold & Vindrola-Padros, 2021). For example, De Kock *et al.* (2021) conducted a rapid review of studies that examined the mental health of HCWs during the early stages of the COVID-19 pandemic. They found that occupational and environmental factors such as heavy workload, proximity to COVID-19, and inadequate PPE were among the most significant risk factors for poor mental health outcomes. They argue that there is a significant need to redirect research activities towards identifying systemic level changes that might enhance the well-being of HCWs (De Kock *et al.* 2021).

A similar programme of research is critically needed in Ireland to document the work-related experiences of HCWs during the pandemic and establish what psychological supports they perceive as potentially valuable. Particular efforts should be made to amplify the voices of those who have been less heard during the pandemic. With this in mind, the authors are currently conducting a two-year qualitative study examining the work-related experiences of HCWs and the particular supports they consider as valuable (if any), with a focus on community psychiatrists and community pharmacists (UCD, 2021). This is one piece of a much broader body of work to ensure that the needs of those HCWs based in community settings are put on the map and brought to the attention of policymakers.

Conclusion

Since the outbreak of COVID-19, a distinction between the experiences of frontline and non-frontline work has been ubiquitous in scholarly and broader public discourse. This distinction is often employed arbitrarily and without a clear definition. In some cases, 'frontline work' has often become narrowly associated with the experience of those working in acute, hospital-based settings. However, there are large numbers of HCWs outside of these settings who continued to have direct contact with healthcare users and the general public throughout the pandemic and thus carried many of the same risks as those working in acute settings. It is the authors' contention that the arbitrary nature of this distinction has significant ramifications in that it serves to: (i) obscure the potentially harmful impacts of the COVID-19 response on large sections of the workforce, particularly those based in primary and community care settings; (ii) belies the significant burden that is likely to fall on primary and community care as the mental health consequences of COVID-19 begin to impact at a population level (Vadivel *et al.* 2021); and (iii) leaves significant sections of the workforce feeling that their contribution to the COVID-19 response has gone unrecognised, with significant knock-on effects in terms of staff morale.

Thus, researchers and policymakers need to adopt a more fine-grained perspective than the binary frontline/non-frontline distinction. Such a perspective recognises that psychological distress resulting from the pandemic was common across all sections of the workforce. However, it also recognises the experiences of HCWs differed depending on whether they were situated in acute or primary settings and whether they were patient-facing or working remotely. Furthermore, the ability to cope with the psychological demands of the COVID response were likely to be shaped by pre-existing working conditions and the adequacy of resources at the disposal of HCWs.

Therefore, as COVID-19 transitions from pandemic to endemic, a more holistic approach to addressing staff welfare that encompasses the entirety of the workforce is needed. Given that much of the burnout is structurally induced, current resilience-based approaches that rely heavily on individual-level interventions are, at best, unlikely to yield significant improvements in psychological well-being. At worst, it may add to a sense of alienation among the very people they are designed to help (Walsh *et al.* 2019; Rose *et al.* 2020). Indeed, there is a risk of a potentially widening gulf between what decision-makers perceive as important in promoting workplace well-being and the lived reality of HCWs where inadequate resourcing, equipment, and remuneration continue to hamper job satisfaction and quality of care (Vera San Juan *et al.* 2020). All of this points to the need for decision-makers to move towards addressing the *structural* resilience of healthcare by attending to the social and material conditions under which teams can prosper (Montgomery, 2021). Such a framework does not disregard the potential usefulness of individual-level interventions as a means of improving staff well-being in a post-pandemic environment. However, it does require an awareness that the outcomes of any complex mental health intervention may be radically different from one context to the next and may generate negative

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unintended consequences as well as positive effects. For example, individuals in hospital-based settings that are more well-resourced may be likely not only to have more time to participate in the offering but also to put new knowledge garnered into practice. In contrast, individuals situated in community-based settings that are operating below recommended resources are not only likely to have less time to participate in the offering but may also view it with a degree of cynicism. Thus, individual-level interventions aimed at promoting well-being need to be evidenced-based, carefully co-created with its intended target group, and its subsequent outcomes closely monitored. Decision-makers thus need to reflect much more critically on the appropriateness of individual-level interventions in a post-pandemic environment and recognise that any individual interventions must run hand in hand with evidence-based structural interventions. In this context, it is useful to bring to mind Maslow's hierarchy of needs (McLeod, 2007). At the core of Maslow's framework is that the psychological needs of human beings can only be met once basic material needs (e.g. security of body, security of employment, security of resources, etc.) are adequately in place (McLeod, 2007). Thus, individual-level interventions, whether introduced into hospital-based settings or primary/community-based settings, are unlikely to have the desired impact as long as there remains longstanding inadequacies in human and infrastructural resources across all sectors of the healthcare system (Walsh *et al.* 2019; Rose *et al.* 2020).

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