AMERICAN
PSYCHIATRIC
ASSOCIATION

COVID-19 Pandemic Guidance Document

REINTEGRATION OF HEALTHCARE WORKERS FOLLOWING COVID SERVICE

Prepared by the APA Committee on the Psychiatric Dimensions of Disaster

The findings, opinions, and conclusions of this guidance document do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association.

BACKGROUND

The COVID-19 pandemic has required contingency and crisis healthcare delivery models in heavily affected regions. Crisis care has led to mobilization of existing and ad hoc healthcare teams to care for high numbers of hospitalized patients. Following the patient surge, existing teams returned to their previously assigned work, and ad hoc teams disbanded and their members returned to their regular work centers. Returning to everyday work following time in a high-demand, high-risk work environment requires a process of readjustment, or re-integration, for most healthcare workers. This document identifies significant stresses either identified or anticipated in workers during re-integration and offers suggestions for mitigating detrimental effects of those stressors.

REINTEGRATION STRESSORS

Processing stressful, traumatic, and morally injurious experiences.
Healthcare workers may have experienced stressful, traumatic, or morally injurious events in the course of COVID service. They may have witnessed severe suffering of patients, and this may be aggravated by insufficient resources or knowledge to most effectively care for their patients.

Sense of safety.
Healthcare workers in COVID service spent significant time in proximity to a highly infectious virus and patients infected with it. Many became habituated to exercising specific protective measures on a daily basis and experience discomfort when those are not practiced with the same rigor in routine settings.

Meaning and identity.
Healthcare workers in COVID service have been recognized widely as heroes. They have worked in cohesive teams with a recognized mission. Return to everyday duties can be associated with a sense of let-down. For ad hoc teams, loss of connection to a group with whom workers have shared significant experiences can also represent a loss of social support.

Adjustment to everyday pace and intensity.
While less stressful, everyday duties may not demand the same immediacy and intensity of communication and task completion. Individuals used to a very demanding and abrupt communication style in a demanding COVID unit may find themselves perceived as irritable or abusive in a routine medical setting. After the critical intensity and urgency of disaster work, normal daily concerns of others may seem petty. While most adapt rather quickly to the change in environment, some may take longer.

Working together following varied experiences.
Some members of existing healthcare teams may have excluded themselves from COVID service, often because of underlying conditions in themselves or family. There is risk that workers who did participate

in COVID service may view these people negatively or as avoiding service. Others may feel guilt for being absent at a time of crisis.

Workplace uncertainty.
Some healthcare organizations are under financial strain and workers may not perceive their jobs as secure upon returning. Lack of clear deployment policies may create expectations that may or may not be met due to marketplace realities, potentially compounding sense of isolation and trauma.

Reintegrating with family.
Some healthcare workers chose to live separately from family during their COVID service. This often results in shifts in responsibility and authority among family members. Establishing new routines is a potential source of stress and conflict.

Childcare concerns.
Childcare has emerged as a continuing concern of many healthcare workers. Some childcare centers have been slow to reopen or are reluctant to accept children of healthcare workers potentially exposed to COVID. Healthcare workers may find it emotionally challenging to place their children back into communal settings due to risk of their children being exposed.

COVID Infection.
We are only now recognizing the long-term consequences of COVID-19 infection, particularly neuropsychiatrically. There are many reports now of persistent fatigue, anxiety, depression, lack of motivation, and neurological sequelae as well. A high percentage of HCWs will have been infected.

ACTIONS

Knowing that such stresses exist, there are steps individuals and organizations should consider to mitigate the negative effects of these stresses.

Psychoeducation.
Provide healthcare workers with information about stressors associated with re-integration, expectable reactions, and tools for self-help. Recognize that many stress responses associated with change may be transient and managed on an individual level with support as needed.

Promoting healthy peer support.
Many systems employed buddy systems during COVID response. Mutual support arrangements are also beneficial in the reintegration period. Having a peer to share experiences with and exchange ideas engages important recovery factors of social connectedness and collective efficacy. This may be particularly important for individuals returning from ad hoc care teams. Encouraging connection back to their COVID team or new local group with similar experiences can also connect them to this support.

Reintegrating workers should be given an opportunity to tell their stories to colleagues in a supported way. This may help to significantly decrease the stigma that comes with being a "hero" and allow a safe space for sharing difficult questions. Such engagement can address isolation in re-integrating workers.

Organizational support.
Messaging from leadership should emphasize that adapting to change is a process. Leaders who share personal examples of identifying their own or their family's stress reactions and how they sought help can destigmatize help-seeking.

Leaders should publicly acknowledge the value of every team member's contribution to efforts against COVID and should discourage singling out individuals perceived as not contributing.

Leaders should communicate lessons learned and improvements that grew out of COVID service. This can be beneficial for individuals struggling with morally injurious experiences to hear that the system hears them and that things will not be the same in subsequent waves.

Organizations should craft policies governing for future deployments of healthcare workers. Such policies should delineate clear and fair rules that promote sense of shared mission and volunteerism and assign value to those who deploy from their organization. Recognition of re-integrating workers can promote a sense of belonging when employee returns to the home organization.

Specialty COVID neuropsychiatric clinics should be developed for treatment of evaluation and treatment of infected workers.

Organizational leaders should survey their employees to understand their childcare challenges, provide information about existing childcare programs, and assist in the development of affordable childcare programs that match the needs of their workforce.

Screening and referral.
Organizations should establish voluntary and confidential screening and referral systems through which individuals can access evidence-based screening instruments. This screening should provide real-time feedback on their level of symptoms and the need for intervention. Individuals with high levels of symptoms or distress should be provided links to available resources, with immediate access if possible. Screening in the absence of appropriate referral services may be detrimental.