Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

The effect of the COVID-19 pandemic on health-care workers

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The COVID-19 pandemic has had a profound impact on the health-care workforce in the UK and worldwide.[1,2] However, in *The Lancet Psychiatry,* Hannah Scott and colleagues[3] report the results of a two-phase epidemiological survey of health-care workers in England, which suggest that prevalence rates based on self-report screening measures might have inflated estimates of mental disorders among health-care staff during the COVID-19 pandemic. The authors report that prevalence rates from a sample of clinical interviews (conducted between March 1 and Aug 27, 2021) were lower than those obtained using screening tools (administered between April 24, 2020, and Jan 15, 2021). The combined population prevalence of common mental disorders (generalised anxiety disorder and depression) was 21·5% (95% CI 16·9–26·8) by clinical interview compared with 52·8% [51·7–53·8] by screening tools, and the estimated population prevalence of post-traumatic stress disorder (PTSD) was 7·9% (4·0–15·1) by clinical interview compared with 25·4% (24·3–26·5) by screening tools. The conclusions of this study raise several discussion points.

First, the screening data were collected between April, 2020 and January, 2021, which corresponded to the peaks of the first and second waves of COVID-19 infection in the UK. By contrast, the clinical interview data

were collected between March, 2021, and August, 2021, which coincided with the easing of social restrictions, mass vaccination of health-care workers and vulnerable adults, and markedly lower rates of mortality than observed earlier in the pandemic.[4] It is possible that health-care workers were experiencing higher rates of anxiety, depression, and PTSD during the screening evaluation, but that prevalence had fallen by the time of the clinical interviews, especially considering that symptoms of mental disorders associated with exposure to traumatic experiences are expected to remit over time due to processes of natural recovery.[5] Scott and colleagues did not readminister screening tools at the time of the clinical interview, therefore it is not possible to definitively attribute differences observed to methods of measurement or changes over time. However, health-care workers in England, and across the world, have continued to face considerable challenges in the workplace, with little time to recover from the effects of the COVID-19 pandemic. Health-care workers are now dealing with a backlog of patients who experienced interruptions to clinical care due to the pandemic, continued staff and resource shortages, and ongoing disputes over working conditions and pay. More high quality longitudinal data are needed to understand the impact of the COVID-19 pandemic and these other adverse circumstances on the health-care workforce over time, and further findings from the NHS CHECK Team and other longitudinal studies are anticipated in the future.

Second, what, and whom, are we missing? The study by Scott and colleagues included measures of common mental disorders (anxiety and depression) and PTSD. Frontline health-care workers from several countries participating in qualitative research are also reporting experiences of stress, burnout, moral injury, and vicarious traumatisation.[6,7] Despite these experiences not being classified as mental disorders, they are often associated with the onset of mental health problems and incur a considerable mental health burden on those affected.[8] Although understandably outside of the remit of the study by Scott and colleagues, it is crucial for future research to investigate and quantify these experiences. The current study is commendable for including clinical and non-clinical staff from both acute hospital and mental health Trusts, but other groups were particularly affected by the pandemic. Family members of health-care workers also report a considerable detriment to their own wellbeing due to their loved ones working on the frontline during the pandemic[9] and mental health professionals who were specifically mobilised to support health-care workers have described feeling ill prepared for this work, overwhelmed, and vicariously traumatised.[10]

Third, is subjective distress important? Scott and colleagues rightly point out that normal distress should not be medicalised and that it is not necessarily the remit of, or best use of, mental health professionals to intervene where individuals are not meeting clinical thresholds for mental disorders. Nevertheless, is it reasonable to expect a workforce to work in a context where more than half are reporting significant distress and over a quarter of individuals are reporting traumatic stress, of sufficient severity to meet cutoffs on mental health screening measures for common mental disorders and PTSD (even if they do not subsequently fulfil diagnostic criteria for a mental disorder)? Should mental health professionals have a role in holding organisations to account for better protecting the mental health and wellbeing of their staff, mitigating preventable distress, and putting appropriate primary prevention strategies in place?

This novel and well conducted study highlights the importance of not relying on screening tools as measures of prevalence and urges against medicalising normal distress. The results also point to the clinical utility of using screening tools to identify staff who are potentially at risk, who can then be followed up with more specific clinical diagnostic interviews. Mental health resources can be targeted at staff most in need, but perhaps also towards trying to effect change at an organisational level.

I declare no competing interests.

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