Health-care workers' knowledge and management skills of psychosocial and mental health needs and priorities of individuals with COVID-19

Ayman Hamdan Mansour, Ahmad N. Al Shibi, Anas H. Khalifeh and Laith A. Hamdan Mansour

Abstract

Purpose – *The purpose of this study is to identify the knowledge and management skills of health-care workers regarding psychosocial and mental health priorities and needs of individuals with COVID-19.*

Design/methodology/approach – *This is a cross-sectional descriptive study. The data collected conveniently from 101 health-care workers in Jordan directly managing care of individuals with COVID-19.*

Findings – *Health-care workers have moderate-to-high level of knowledge and management skills of psychological distress related to COVID-19; means ranged from 50%–70% agreement and confidence. In general, health-care workers were able to identify mental and psychosocial health needs and priorities at a moderate level. Health-care workers knowledge had a positive and significant correlation with age (r = 0.24, p = 0.012) and years of experience (r = 0.28, p = 0.004), and a significant difference was found in their management between those who are trained on psychological first aids and those who are not (t = −3.11, p = 0.003).*

Practical implications – *There is a need to train health-care workers to integrate psychosocial and mental health care to manage care psychological distress related to COVID-19.*

Originality/value – *This study is emphasizing the need for mental health psychosocial support training and in integration. Health-care workers providing care to individuals with COVID-19 are not aware of mental health priorities and needs of their patients. This paper contributes to the body of knowledge adding more understanding about competencies of health-care workers providing care and their preparedness to manage care individuals with COVID-19.*

Keywords COVID-19, Mental health, Psychosocial care, Health-care providers, Mental health priorities, Mental health needs

Paper type Research paper

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Introduction

The outbreak of COVID-19 across the world has forced many countries to call for emergency plans. The pandemic of COVID-19 globally has interrupted the social and economic lives. Many countries around the world transformed to online teaching and banned social and formal gathering and public transportation to minimize its contagiousness and lethality. Although emphasis is certainly needed and, eventually, geared toward medical treatment and vaccination, mental health and psychosocial care is still a priority that requires attention and enforcement (Inter-Agency Standing Committee [IASC], 2007). In Jordan, affected individuals with COVID-19 were isolated and treated in medical and well-designated units. Until May 12, the Ministry of Health in Jordan

announced 576 confirmed case; 9 deaths and 390 recovered (www.moh.gov.jo). Although the outbreak seems not equal to neighboring countries, the public authorities announced lockdown and curfew for few days and then partially until further notice.

Health-care workers, across all disciplines and owing to variation in specialization and scope of work, vary in their abilities to provider psychosocial and mental health care to meet their patients' needs. Health-care workers are still committed and responsible for the holistic care provided to their patients and beneficiaries (Griffiths *et al.*, 2017), while focusing and ware of precaution given to the contagiousness form of COVID-19. Psychosocial and mental health care is considered one core component of all health-care workers' responsibilities that contribute to patients' satisfaction and quality of care (International Council of Nursing [ICN], 2013). Psychosocial and mental health care needs and priorities of individuals of COVID-19 were created comparative to other outbreaks such as Ebola and SARS (Inter-Agency Standing Committee [IASC], 2007). Jordan is uniquely experiencing such a situation in which most of these measures and methods of intervention never been tested and validated among Jordanian people. A recent study showed that health-care workers have never had the opportunity to consolidate their training regarding providing mental and psychosocial care to their patients across medical complaints, in particular, those suffering psychological distress related to sever medical problem (Al Shibi, and Hamdan-Mansour, 2020). Therefore, lack of information is noted regarding general medical practitioners and health-care workers' information and management ability to integrate psychosocial and mental health care of individuals with COVID-19. The World Health Organization (WHO) demands that health-care teams be equipped with mental health capacities and the ability to provide essential mental health and psychosocial support services (World Health Organization [WHO], 2020). It has been also reported that mental health needs of patients with confirmed COVID-19, suspected ones and medical personnel have been poorly handled in China (Duan, and Zhu, 2020). Thus, integrating mental health and psychosocial care into routine health-care practices is becoming a demand of quality of care. Many reasons may compromise mental health of individuals with COVID-19 and expected to affect negatively their prognosis and recovery. It is well acknowledged that individuals with confirmed COVID-19 are suffering physical and psychological problems (Liebrenz *et al.*, 2020). The severity of physical signs and symptoms has also affected negatively mental status of the individuals with COVID-19 (Li *et al.*, 2020). In addition, it was found that females with COVID-19 with poor self-rated of health status and signs of specific physical symptoms such as myalgia and dizziness had higher levels of stress, anxiety and depression (Beaujouan, 2020). This infers that appropriate management of mental health needs and identifying priorities of individuals with COVID-19 is necessary to improve mental and physical health of individuals with COVID-19. Managing psychological distress, mental health related factors and providing appropriate psychosocial care were associated with decreased workload, physical complaints and financial burden of health-care services, as well (Al Shibi, and Hamdan-Mansour, 2020). Such reports enhanced the reciprocal benefits of appropriate management of psychological distress (MPD) between health-care workers and their patients confirmed with COVID-19. Health-care workers at the frontline with COVID-19 are handling complicated procedures, overloaded and not specialized in mental health or psychosocial support (Duan, and Zhu, 2020). Generally, we lack the information whether health-care workers are aware about the components of psychosocial care and mental health needs and priorities of individuals with COVID-19. In addition, health-care workers lack the appropriate connection of physical and mental health components. The international guidelines are recommended including specialized mental health personnel to manage psychological and mental health problems caused by epidemics and other public health emergencies (World Health Organization [WHO], 2020). Therefore, the *purpose* of this study is to identify knowledge and management of psychosocial and mental health priorities and needs of individuals with COVID-19.

Methods

Design: Cross-sectional descriptive-explorative design was used to collect data from health worker caring of individuals confirmed with COVID-19. Data were collected in relation to mental and psychosocial health priorities, health-care workers knowledge and management skills of mental and psychosocial support needs using structured electronic format of data collection.

Sample and setting: A convenience sampling technique was used to recruit 101 health-care workers caring of individuals with COVID-19. The sample recruited from all health-care settings in Jordan. Inclusion criteria include active health-care worker working directly with individuals with COVID-19. Exclusion criteria include health-care workers confirmed with COVID-19, as these health-care workers might conflict their mental health needs as care providers and as patients.

Data collection procedure: Ethical approval of the ethical committee (IRB) obtained from the XX university prior to data collection. The research used the network approach to recruit the sample of this study. The researchers used the social media and networking to announce this study, its purpose and significance. The announcement also included information related to title, confidentiality, privacy of information and that this study will be anonymous. Those interested in participation were asked to contact the research team and provided with the online survey. The contact information of the researchers was available to answer have all participants' questions prior starting filling out the survey. The survey took an average of 10 min to be filled out. The researchers sent the electronic survey via email for those who wish to have the survey sent to them via email. All data kept in a secured computer at the researcher's office.

Measurement: Data collected using an adapted self-reported survey using international studies and guidelines. Translation of the priority tool conducted according to WHO guidelines. Pilot testing conducted (*n* = 10) to check on understanding, clarity and time required for completing the survey. In addition, a brief author-developed profile questions added to obtain demographic information.

The tools are formed of two main parts:

1. *Part one*: formed of three main sections: knowledge of psychological distress, managing mental health consequences of psychological distress related to COVID-19 and knowledge about signs and symptoms of psychological distress related to COVID-19. The three sections are, eventually, adapted from the Arabic version of knowledge and management of patients with psychological distress (KMPSD) and physical and psychological signs and symptoms of psychological distress (SSPSD) (Al Shibi, and Hamdan-Mansour, 2020). The scale adapted to integrate information related to mental health care of COVID-19 using the international guidelines (Inter-Agency Standing Committee [IASC], 2007; World Health Organization [WHO], 2020). Section one formed of 28 items regarding essential information about the psychological distress related to individual confirmed with COVID-19. The health-care workers are required to make their responses using a visual analogue scale (VAS) with responses ranging from 0 (not confident at all) to 10 (very confident). Part two, items 28–36, was designated to measure managing mental health consequences of psychological distress related to COVID-19 using the same VAS. Part three, items 37–51, is measuring knowledge regarding the physical and psychological signs and symptoms of psychological distress related to COVID-19. The health-care workers are asked to make their responses on scale of three response: yes (2); do not know (1); and no (0). The responses of "no" and "do not know" were then merged as both responses would indicate that health-care workers do not have the information or think it is not the correct one indicating inappropriate acquisition of information and considered as faulty response. The scale has good reliability with Cronbach's alpha 0.89 for MPSD, 0.73 for SSPSD and 0.90 for SPSD (Al Shibi, and Hamdan-Mansour, 2020). In this study, the three scales have also good reliability with Cronbach's alpha of 0.96, 0.90 and 0.84, respectively.

2. *Part two*: mental and psychosocial health priorities and needs. The survey is formed of 24 items related to mental and psychosocial health priorities and needs as recommended by the international agencies and guidelines of mental health needs of patients in outbreak crisis [1, 6]. The scale formed of two sections: Section 1 is formed of 13 items asking the health-care workers to make their responses on a Likert scale ranging from 0 (not a priority at all) to 5 (urgent priority). Section two is formed of 11 items asking questions related prioritize the health-care needs of their patients on a scale of 0 (not a priority at all) to 5 (urgent priority). The scale has a good reliability with Cronbach's alpha of 0.90 for the whole scale and 0.82 and 0.86 for the priorities and needs subscales, respectively.

Data analysis plan: data will be analyzed using the Statistical Package for the Social Sciences (SPSS) version 24 software (IBM Corp., 2018). The variables described using frequency tables and the central tendency measures (mean and median) and dispersion measures (SD, variance and range). To assess the correlation between the variables, Pearson correlation coefficient (r) used and t-test for independent sample and ANVOA used to test the differences related to demographic and personal characteristics. Alpha was set to 0.05.

Results

Demographic characteristics

A total of 101 health-care workers accepted and filled out the survey that was sent online. The mean age was 34.5 (SD = 8.0) ranging from 23 to 55 years. In total, 69.3% (n = 70) were males and 31.7% (n = 31) were females. The majority were nurses (71.3%, n = 72) and 18.8% (n = 19) were physicians, while 10% were pharmacists, public health inspectors and counselors and had also bachelor's degree (65.3%, n = 66) and 21.85 (n = 22) had master's degree. The mean years of experience in profession was 11.6 (SD = 7.9) ranging from 1 to 30 years. About 46.7% of them (n = 47) had training in psychological first aid, 36.6% (n = 37) had experience in mental health care and the same percentage (36.7%, n = 37) had special training in mental health care.

Knowledge about mental and psychosocial care

The analysis (Table 1) showed that total mean score for the whole scale of the knowledge about the mental and psychosocial care, using VAS of 0 to 10, was 6.58, SD = 0.75 ranging from 5.18 to 7.82, indicating moderate level of knowledge of health-care workers related to mental and psychosocial care of individuals with COVID-19. The highest three mean item scores observed were "Providing quiet place" (M = 7.82, SD = 2.28), "Using body language therapeutically" (M = 7.47, SD = 2.31) and "Using scientific/therapeutic method to communicate information and bad news" (M = 7.26, SD = 1.95). On the other hand, the lowest three mean item scores were "Recognizing patients who need a referral for psychological therapist for follow-up" (M = 5.90, SD = 2.49), "Using psychological support with explanation of physical symptoms and examinations" (M = 5.84, SD = 2.43) and "Making evaluation that includes history, physical and mental evaluation and routine checks" (M = 5.18, SD = 2.18). The mean score indicates that health-care workers are knowledgeable about the main principles of therapeutic communication and management of patients' needs. However, knowledge about needs of referral, providing psychosocial care or areas that needs knowledge about assessment and evaluation of psychological status of patients were the lowest.

Managing psychological distress

Regarding health-care workers' MPD, the analysis (Table 2) showed that the total mean score for the whole scale, using VAS of 0 to 10, was 7.41 (SD = 0.48) ranging from 6.49 to 8.09. The results indicate that health-care workers have moderate to high level of agreement

Table 1	Mean item scores of knowledge about mental and psychosocial care among health-care workers caring of individuals with COVID-19 (N = 101)		
Items		*Mean*	*SD*
Providing quiet place		7.82	2.28
Using body language therapeutically		7.48	2.31
Using scientific/therapeutic method to communicate information and bad news		7.26	1.95
Using breathing exercise and relaxation with individuals with corona virus		7.18	2.01
Using skills for therapeutic dialogue		7.14	2.23
Using active listening		7.09	2.18
Building a trust relationship		6.97	2.29
Providing care commensurate/appropriate to individuals with corona virus' culture		6.93	2.56
Reducing the surrounding environmental effects (disturbance and loud voices)		6.90	2.36
Use psychological support, assurance and normalization technique without explanation of physical symptoms and other tests		6.81	2.12
Using a therapeutic environment to make an appropriate evaluation for both the patient and their families		6.79	2.48
Use positive debriefing technique ways to summarize the information		6.77	2.39
Provide a safe environment for the individuals and their families to meet in privacy and comfort atmosphere		6.69	2.34
Distinguishing repeated health complaints that are not physically based		6.55	2.47
Evaluation of individuals with corona virus regarding suicide, stress or agitation		6.51	2.36
Providing psychological counseling/guiding		6.42	2.35
Meet the psychological needs of individuals with corona virus in isolation		6.37	2.29
Using "positive self-talk" method with individuals with corona virus		6.36	2.33
Promote constant communication between the individuals with corona virus and their families		6.33	2.41
Evaluate and interview individuals with corona virus & their families in a place that preserves privacy		6.31	2.62
Knowing anti-anxiety medication or its sedative effects		6.07	2.53
Classification and evaluation of individuals with corona virus in proper isolation		6.06	2.27
Use a pre-designed classification system or assessment tool to provide the necessary care for individuals with corona virus in isolation		6.06	2.27
Carry out a physical assessment to see if the actual cause of the current complaint is an organic/physical or psychological one		6.06	2.43
Provide privacy		6.05	2.46
Recognizing patients who need a referral for psychological therapist for follow-up		5.90	2.49
Use of psychological support with explanation of physical symptoms and examinations		5.84	2.43
Make an evaluation that includes history, physical and mental evaluation and routine checks		5.18	2.67
Total scale		*6.58*	*0.57*

on what and how psychological support and mental health care should be provided to individuals with COVID-19 in isolation. The highest mean item score was observed in "*The longer the treatment or isolation period, the greater the chance of developing psychological distress in individuals with COVID-19 in isolation*" (M = 8.09, SD = 2.0), while the lowest mean item score was observed in "*Psychological distress due to isolation may cause non-cardiac chest pain*" (M = 6.49, SD = 2.11).

Psychological distress signs and symptoms

Regarding health-care workers' knowledge of signs and symptoms of psychological distress of individuals with COVID-19, the analysis (Table 3) showed that anxiety and fear, general body aches, fatigue, tension and irritability, anger and confusion, difficulty concentrating and mental distraction were the most reported responses. While, muscle spans, feeling detached and easily panicked (hypervigilance) were the least reported

Table 2 Mean item scores of perspectives toward psychological care among health-care workers caring of individuals with COVID-19 (*N* = 101)

Items	Mean	SD
The longer the treatment or isolation period, the greater the chance of developing psychological distress in individuals with COVID-19 in isolation	8.09	2.00
Psychological distress may cause harmful behaviors to individuals with COVID-19	7.65	2.05
Using therapeutic stress management techniques help to prevent and reduce psychological distress symptoms for individuals with COVID-19 in the isolation	7.62	2.05
Stigma or discrimination leads to psychological distress for individuals with COVID-19 in isolation	7.59	2.54
Psychosocial support skills useful to treat psychological distress for the individuals with COVID-19 in isolation	7.57	1.79
Unmet psychological needs of individuals with COVID-19 in the isolation may cause non-cardiac chest pain	7.28	2.06
The short-term use of emotionally focused therapy helps to prevent and treat psychological distress in individuals with COVID-19 in isolation	7.03	2.04
Psychological distress due to isolation may cause non-cardiac chest pain	6.49	2.11
Total scale	*7.42*	*0.48*

responses. The results, in general, show that health-care workers caring of individuals with COVID-19 in isolation do not have the appropriate knowledge about the physical and psychological signs of psychological distress. Their responses ranged from 51 to 88 with mean of 72.7 (SD = 12.1) indicating marginal and almost moderate level of knowledge of physical and psychological signs and symptoms of psychological distress.

Psychosocial and mental health priorities and needs

Regarding health-care workers' knowledge of mental and psychological priorities and needs of individuals with COVID-19 in isolation, the analysis (Table 4) showed that > 82% of the priorities were listed as moderate to urgent priority with the majority (61%–71%) of responses were listed as moderate to high ones. The most report urgent priorities were "Fear of losing beloved people owing to illness" (38%), "Fear of being in sanitary insolation" (28%) and "Lack of information about the disease" (28%), while the least urgent priority was

Table 3 Knowledge of health-care workers regarding signs and symptoms of psychological distress among individuals with COVID-19 in isolation (*n* = 101)

	Yes	
Items	n	(%)
Anxiety and fear	88	82.1
General body aches	84	83.3
Fatigue	84	83.3
Tension and irritability	84	83.3
Anger	81	80.2
Confusion, difficulty concentrating and mental distraction	80	79.2
Shock, denial or disbelief	78	77.2
Pounding heart	78	77.2
Withdrawal (isolation) from others	75	74.3
Feeling sad and hopelessness	68	67.3
Insomnia, nightmares or sleep disturbances	68	67.3
Feelings of guilt, shame and self-blame	60	59.4
Muscle spasms	59	58.4
Feeling of detachment	53	52.5
Easily panic (hypervigilance)	51	50.5

Table 4 Knowledge of health-care workers regarding psychosocial and mental health priorities among individuals with COVID-19 in isolation (*n* = 101)

Items	Not to low priority n	(%)	Moderate to high priority n	(%)	Urgent priority n	(%)
Fear of dying from the illness	17	16.8	63	62.4	21	20.8
Fear of losing physical ability	16	15.8	76	75.2	9	8.9
Fear of losing work and job	18	17.8	68	67.3	15	14.9
Fear of social isolation	15	14.9	66	65.3	20	19.9
Inability to sleep	13	12.9	73	72.3	15	14.9
Physical pain due to illness	12	11.9	73	72.3	16	15.8
The future's ambiguity/uncertainty about disease	10	9.9	69	68.3	22	21.8
Lack of information about the disease	11	10.9	62	61.4	28	27.7
Fear of being in sanitary insolation	9	8.9	66	65.3	28	27.7
Fear of losing beloved people due to illness	3	3.0	63	62.4	35	34.7
Fear of being separated from beloved people	6	5.9	74	73.3	21	20.8
Feeling powerless/helpless due to inability to help beloved people	7	6.9	75	74.3	19	18.8
Fear of being discriminated or stigmatized	17	16.8	69	68.3	15	16.8

"Fear of losing physical ability" (9%). Interestingly, 17% of the health-care worker reported that "Fear of dying from the illness" and "Fear of being discriminated or stigmatized" as not to low priority. The results indicate that although health-care workers were able to identify priorities of mental and psychosocial care, these priorities were considered as moderate to high and not given the urgency status.

Knowledge of health-care workers regarding psychosocial and mental health needs

Regarding the psychosocial and mental health needs (Table 5), the analysis showed that 15% of health-care workers reported that "Reducing watching, reading or listening to the news" is either not a priority or low priority need for the individual with COVID-19. While, 32% reported that "Using methods of reassurance and normalization that the infection with COVID-19 is not a stigma or shame" and 31% reported "eating health food" as urgent need. However, in general, most of the reported needs were reported as moderate to high.

Table 5 Knowledge of health-care workers regarding psychosocial and mental health needs among individuals with COVID-19 in isolation (*n* = 101)

Items	Not to low priority n	(%)	Moderate to high priority n	(%)	Urgent priority n	(%)
Providing psychosocial support through informal networks (families)	6	5.6	70	69.9	25	24.8
Providing psychological and social support through health/psychological professionals	2	2.0	71	70.3	25	24.8
Maintaining patients' communication and social networks	7	6.9	71	70.3	28	27.7
Using methods of reassurance and normalization that the infection with COVID-19 is not a stigma or shame	5	5.0	63	62.4	33	32.7
Engaging in healthy activities that bring enjoyments and relax	2	2.0	76	75.2	23	22.8
Doing exercise regularly	9	8.9	75	74.3	17	16.8
Maintaining a regular sleep routine	4	4.0	75	74.3	23	22.8
Eating healthy food	3	3.0	74	66.3	31	30.7
Reducing watching, reading or listening to the news	15	14.9	65	64.4	21	20.8
Providing patients with facts and updates about COVID-19 from reliable sources in an appropriate and brief manner	4	4.0	70	69.3	27	26.7
Meeting the special needs of the patients, for example, the special needs of women, children and elderlies or being patient with a disability	6	5.9	67	66.3	28	27.7

Difference related to sociodemographic factors

Regarding differences in knowledge and skills of mental and psychosocial care (KSMPC), MPD, and psychological distress signs and symptoms in relation to sociodemographic factors, the analysis showed that KSMPC had positive and significant correlation with age ($r = 0.24$, $p = 0.012$) and years of experience in profession ($r = 0.28$, $p = .004$). While, MPD and PDSS had no statistically significant correction with age and years of experience ($p > 0.05$). Using t-test for two independent variable, there were also no significant differences in KSMPC, MPD and PDSS in relation to gender ($p > 0.05$), while significant difference was found in MPD between those who are trained on psychological first aids (PFA) and those who are not ($t = -3.11$, $p = 0.003$), with mean score of those who received PFA (63.43, SD = 11.15) higher than those who did not (M = 55.76, SD = 13.54). On the other hand, no differences in KSMPC and PDSS in relation to PFA found although means of those with PFA training were also higher than those who did not. Moreover, significant differences were found in PPD ($t = -3.73$, $p < 0.011$) and KSMPC ($t = -3.92$, $p < 0.001$) in relation to past experience in mental health care. Mean score of those with mental health care experience was higher in KAMPC (M = 207.3, SD = 40.9) than those with no mental health experience (M = 170.3, SD = 48.2). Similarly, those with mental health care experience had higher mean score of PPD (M = 65.3, SD = 8.2) than those who did not (M = 55.9.3, SD = 14.1). No statistical difference found in PDSS in relation to experience in mental health care. In addition, the analysis showed that there was a significant difference in KSMPC and PDSS in relation to specialty ($F_{4,96} = 2.81$, $p = 0.030$; $F_{4,96} = 2.68$, $p = 0.036$, respectively), while no significant difference found in MPD ($P > 0.05$). The analysis also showed that public health inspectors had the highest mean score of KSMPC (M = 200.80, SD = 67.88), counselors had the highest mean score of PDSS (M = 29.00, SD = 1.41) and physician had the highest mean score of MPD (M = 60.21, SD = 4.77). Nevertheless, the post hoc comparison, using Bonferroni, showed that the only differences observed were between nurses and physician in KSMPC ($p = 0.012$).

Discussion

Holistic care is one core principle of quality of health-care services. Health-care providers assumed to have the knowledge and skills and high level of awareness about mental health needs and priorities, in particular, for individuals distressed because of serious medical problems. We found that health-care workers have moderate level of knowledge and management skills of psychological distress among individuals with COVID-19. We have also found that health-care workers have recognized moderately mental and psychosocial priorities and needs. Nevertheless, being at the moderate levels would question how health-care workers balanced physical and psychological needs of their patients. We would assume that all listed psychological and mental health needs will be given high-to-urgent level of priority (Inter-Agency Standing Committee [IASC], 2007; World Health Organization [WHO], 2020), while the results of this study showed that the majority reported moderate to high priority. The results correspond with a recent study (Duan, and Zhu, 2020) that health-care workers caring of medically compromised patients confirmed with COVID-19 suffering psychological distress are not specialized in mental health. Therefore, mental and psychosocial care is not provided adequately to those patients. One explanation is that health-care workers caring of patients confirmed with COVID-19 are overwhelmed with physical care and under strict precaution of contact and interaction with their patients whom isolated. Thus, their perception and prioritization of mental and psychosocial health care needs might be related to their limited physical contact with their patients. Another explanation is related to their mental and psychological first aids experience. We found that those who have mental health background and psychological first aid training had higher mean scores than those who do not. The results correspond with equivalent previous studies (Al Shibi, and Hamdan-Mansour, 2020; World Health Organization [WHO], 2019)

that nurses in emergency unit who have mental health background or received special training in mental health were able to assess psychological distress and had higher level of knowledge and management skills. This is significant information considering recent studies whom found also that individuals with confirmed COVID-19 are suffering physical and psychological problems (Liebrenz et al., 2020) and that severity of physical signs and symptoms have also affected negatively their mental status. Therefore, there is a need to integrate physical and pharmaceutical treatment with psychological intervention to improve the treatment outcomes. Even though, health-care workers in this study do not prioritize highly psychological and social support, the need to refer them to specialized psychological professionals. This could sustain the notion that health-care workers are prioritizing physical health needs much more than they do for mental and psychological needs which comes in contrast with the international guidelines (Inter-Agency Standing Committee [IASC], 2007; World Health Organization [WHO], 2020, 2019). Compromising mental health needs would negatively affect physical health and prognosis of their patients with COVID-19. Health-care workers need to be exposed to psychological distress scenarios and management protocols to acquire the knowledge and skills to appropriately manage psychological distress in such pandemic situation. Studies have eventually found that such training and education is very feasible and have promising outcomes (Fawaz, and Hamdan-Mansour, 2016; Fawaz et al., 2018; Sivakumar et al., 2011).

In this study, we found that male and female health-care workers are not different in their reports and only more years of experience and receiving mental health training did associate positively with knowledge and management skills of psychological distress. Furthermore, it is worth to mention that health-care workers, owing to treatment protocols of individuals with COVID-19 in isolation and the high contagiousness of the virus, are also subject to psychological trauma (Ratrout, and Hamdan-Mansour, 2020). This would negatively affect the health-care workers' ability to recognize their patients psychosocial and mental health needs. Moreover, using the personal protective equipment do interrupt health-care workers' communication and quality of interaction with patients owing to serious physical threat of COVID-19 that would also jeopardize the situation.

Conclusion

The study has significant implications for health-care workers and quality care managers. The findings identified gaps in the integration between various aspects of health care in which health-care professionals are not prioritizing highly mental health psychosocial support services (needs and priorities) as much they do for the physical aspects. This study showed that there is an urgent need for health-care staff to integrate both physical and mental health skills and knowledge to improve health-care outcomes of patients with COVID-19. Health-care workers are required to improve their knowledge to identify the psychological and physical signs and symptoms of psychological distress and skills to provide proper care for patients with COVID-19. There is a need to pose training and preparing health-care professionals to proper management of medically compromised patients.

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