

Social workers' experiences in integrated health care during the COVID-19 pandemic

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Abstract

- *Summary:* The massive spread of the novel COVID-19 virus across the globe has been disruptive to all providers within integrated healthcare systems, including social workers. The literature on how the pandemic has impacted medical workers are emerging. The present article explored the experiences of social workers. A purposive sample of 40 social workers in integrated healthcare settings was interviewed from September to November 2020 prior to vaccine availability to learn about how they managed the earlier months of the pandemic. A constant comparison approach was used to analyze the data.
- *Findings:* Themes identified included: (1) how social workers felt about safety in their work environments; (2) what it was like for social workers to transition to remote work; (3) how the pandemic affected social workers' workload and mental health; and (4) what were the preparedness issues and lessons learned.
- *Applications:* This study adds to the existing literature on provider experiences of the pandemic in integrated health care with social workers' voices. This additional perspective may contribute to better preparedness of behavioral health services and taking care of social workers in future crises.

Keywords

Social work, medical social work, social work practice, behavioral health, mental health, crisis preparedness

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Introduction

The Coronavirus Disease 2019 (COVID-19) pandemic has challenged the healthcare system in myriad ways with devastating consequences in the United States. The many abrupt changes due to requirements of the pandemic that include shelter-in-place orders, quarantining, and social distancing may lead to increased apprehension among staff (Sharif et al., 2020) and patients. Literature is emerging on the disruption and consequences of the pandemic on medical providers (Britt et al., 2021; Lai et al., 2020; Salas-Vallina et al., 2020; Sharif et al., 2020) in integrated health care, which is defined as the coordination of care between behavioral health and physical health by an interdisciplinary team to address the comprehensive needs of patients (Reamer, 2018). The interdisciplinary team is made up of a variety of professionals such as social workers, psychiatrists, primary care physicians, and nurses to holistically treat patients together. The workforce in integrated health care was already exposed to increased stress and burnout prior to the COVID-19 pandemic in the United States (Rodriguez et al., 2020). The onset of the COVID-19 pandemic may create additional challenges for providers having to manage heavy workloads and function in an emotionally demanding environment (Salas-Vallina et al., 2020). Accordingly, research is needed to understand how providers experienced the pandemic in the United States. Among medical providers, pandemic-related job demands have been found to be risk factors for a greater likelihood of mental health challenges (Britt et al., 2021). Despite social workers being an essential part of integrated healthcare settings, a paucity of research is focused on how this profession has dealt with the pandemic. Therefore, to address the gap in the literature, the goal of this article is to explore the experiences of social workers. Filling this gap in the literature will provide a more comprehensive review of how all providers in integrated healthcare settings functioned during the COVID-19 pandemic.

Literature review

Medical staff

Even before the COVID-19 pandemic, medical staff were found to experience burnout and various stresses. Specifically, 50% of physicians and 76% of residents reported burnout (Lin et al., 2019; Rotenstein et al., 2018). Emergency medical providers faced a variety of stressors such as overcrowding, high workloads, and bureaucratic activities that were viewed as excessive (Schneider & Weigi, 2018). With the onset of the COVID-19 pandemic in 2020, pandemic-related demands on top of existing stressors can magnify providers' mental health (Britt et al., 2021) and may negatively affect patients' care. Scholars have already found that the pandemic has provoked distress and apprehension (Lai et al., 2020) as well as anxiety and depression (Sharif et al., 2020) among medical workers. The constant safety protocol updates were found to contribute to medical staff experiencing high levels of stress (Salas-Vallina et al., 2020). Among emergency medical personnel, Britt and colleagues (2021) found COVID-19 demands and hours worked were associated with increased mental health strain. Also

among emergency physicians, Rodriguez and colleagues (2020) found fear of exposing loved ones to the virus and having inadequate personal protective equipment (PPE) such as masks. According to Lai and colleagues (2020), limited PPE and lack of knowledge on how to best optimize scarce resources can increase healthcare workers' anxiety, distress, panic, and apprehension. Among neurosurgeons worldwide, Sharif and colleagues (2020) found respondents had suicidal ideation (5%), depression (14%), headaches (20%), insomnia (25%), unhappiness (25%), and tension (34%) during the pandemic. These experiences were found to be predictive of burnout among healthcare professionals (Sharma et al., 2021).

Social workers

Social workers are a vital and integral part of the complex healthcare system with specialized training, values, skills, and knowledge (Heenan & Birrell, 2019). Yet, this group of professionals' experiences during COVID-19 pandemic are largely missing in the literature. As members of interdisciplinary teams, social workers practice alongside medical providers to help patients through physical and behavioral challenges so that patients can live independently and safely within their communities (Heenan & Birrell, 2019). Social workers systematically consider biological, psychological, social, cultural, and spiritual factors as well as their complex interactions to holistically assess and address the well-being of patients (Heenan & Birrell, 2019; Raju et al., 2016). This comprehensive approach helps interdisciplinary teams to more accurately diagnose and treat patients. Social workers address the social and emotional needs of patients through multiple roles of counselor, advocate, educator, support, and referral for patients (Barach et al., 2020; Heenan & Birrell, 2019; Raju et al., 2016). Social workers' unique strengths-based perspective that focuses on the strengths of patients rather than their challenges assists patients to realize their resiliency and ability to improve their well-being (Heenan & Birrell, 2019). Social workers also assist patients and their families to navigate the complex healthcare system, ensure their decisions are heard, and have the coping skills needed (Heenan & Birrell, 2019; Raju et al., 2016). Lastly, increases in patient follow-up rates are attributed to social workers (Raju et al., 2016).

The literature on work-related experiences in integrated health care prior to the COVID-19 pandemic has centered on medical professionals (Lin et al., 2019; Rodriguez et al., 2020). Much of the research conducted with providers in health care during previous virus pandemics and epidemics has also focused on medical personnel including the emerging research on the COVID-19 pandemic (Britt et al., 2021; Rodriguez et al., 2020; Sharif et al., 2020). The pandemic in general has been found to provoke distress, apprehension, anxiety, and depression among medical providers (Lai et al., 2020; Sharif et al., 2020). The effect on social workers within the same settings is largely missing in the literature. Social workers are crucial members of integrated healthcare teams who work with medical staff to assist patients and their families on issues of behavioral health. Therefore, this specific group of professionals is unique and important to investigate. This study addresses the gaps in the literature by examining how social workers in integrated healthcare settings managed the pandemic.

Research method

Similar to Heenan and Birrell's (2019) study of social workers in a hospital, a qualitative approach was utilized because of the exploratory nature of this study. According to Nelson and Merighi (2002), qualitative approaches can provide a means to understand the context of practice and offer guidance for future research. The research question posed for this study was: How did social workers manage the COVID-19 pandemic in integrated healthcare settings? Ethical clearance was obtained from the California State University, Long Beach Institutional Review Board (IRB).

Sampling

Potential participants were identified through the research team's network of who they know might qualify to be a part of the study. Therefore, sampling was purposive and participants had to meet the following criteria: (1) employed as a social worker in an integrated healthcare setting; (2) have at least two years of experience in the setting; and (3) have the experience of being impacted by the pandemic at their agencies. Using an approved IRB recruitment script, individuals were assessed as to whether they qualified to be a part of the study and if they did, were informed about the study, and asked about their willingness to participate. Recruitment resulted in 40 participants being interviewed. Participants' integrated healthcare practice experience ranged from 3 years to 30. Gender identification among participants included 31 females and 9 males. The racial breakdown of participants was 4 African American, 2 Asian American, 17 European American, 14 Latinx American, and 3 multiracial. All participants had social work degrees that included 1 Bachelor of Social Work (BSW), 36 Masters of Social Work (MSW), and 3 PhDs. Integrated healthcare settings in which participants worked included skilled nursing facilities, adult day-care centers, hospice programs, home health, Veterans Affairs clinics, residential treatment facilities, mental health clinics, psychiatric hospitals, various units within hospitals, and acute hospitals.

Data collection

The study involved semi-structured interviews conducted between August and November 2020. After confirmation that potential participants met the study criteria and were willing to be a part of the study, interviews were scheduled at a time of each participant's preference. Prior to each interview, informed consent was obtained and all questions about the study were answered. All members of the research team followed an interview protocol to stay consistent between interviews. The outline of the protocol consisted of an introduction to the study, the process for the interview, and open-ended questions that allowed interviewers to ask follow-up and clarification questions. All answers were audio-recorded and transcribed to ensure the accuracy of the data.

Data analysis

All participant identifiable information was removed prior to data analysis. Data from the transcripts were compiled in NVivo to organize and conduct data analysis. Data analysis

followed the constant comparison approach by Glaser and Strauss (1999). The goal of the approach was to identify patterns and themes by finding concepts and relationships between categories. The first step entailed open coding of breaking down data into small units that could be on their own. This step helped to detect repeated patterns. The next step was to sort the units from step one into categories. The categories were needed to develop emerging themes. The third step involved comparing and contrasting each unit within each category against all other codes and categories. The goal of this step was to ensure all units and categories were consistent and units belonged to their respective categories. When necessary, units were moved to the appropriate categories, categories were merged, and categories were further broken down. The last step of data analysis consisted of linking the categories to develop themes in order to tell a story.

Methodological integrity

This study used multiple measures to ensure methodological integrity of the qualitative data. One way was through member checking, which meant that the data collected were verified with participants. According to Rodwell (1998), member checking validates the data. Another way to validate the data was the checking of transcriptions to ensure accuracy. To maintain consistency throughout the project, methodological journaling was implemented for all decision-making. This process entailed the researcher tracking all the decisions made and ensuring the research team followed each of the decisions.

Results

The pandemic has had drastic effects on integrated healthcare social workers in a variety of ways. This study set out to understand those experiences up to November 2020. The themes found in this study consisted of: (1) how social workers felt about safety in their work environments; (2) what it was like for social workers to transition to remote work; (3) what was the workload like and how the pandemic it affected social workers' workload and mental health; and (4) what were the preparedness issues and lessons learned. The following sections provide an in-depth analysis of the themes. Quotes from participants are provided to give them a voice. Each quote includes initials that were randomly selected to represent specific participants to maintain confidentiality.

Safety in the work environment

For the most part, many participants believed that their agencies well navigated the pandemic, prioritizing the safety of patients and staff, and helping staff feel supported thus far to provide needed services. Nonetheless, the novelty of COVID-19 created many challenges that social workers were a part of and affected their work. At the beginning of the pandemic in 2020, safety guidelines were changed on a regular basis as new information became known about the virus. For instance, one participant described the situation in this way: "It just felt like total chaos constantly" (JW). As guidance changed, operationalization of new practices, assurance of follow-through, and reporting would also

be necessary. Some participants were frustrated with the inefficiencies of the whole process. One participant remarked: "I literally felt that we were creating the wheel as we were going through it; every day it was something new" (SC). The unknowns about the virus meant patients canceling appointments and staying away in fear of getting infected at first. For one participant, "...about half of our patients did not want to have contact with us..." (BD).

As agencies became more organized following federal and local guidelines, safety plans were developed for the agency as a whole as well as for the different functional areas related to occupancy rates, sanitation procedures, mask requirements, and the like. One of the changes that social workers discussed at length was the physical distancing requirements. Participants reported their agencies having to find additional workspaces and/or different times employees could come into the office given their limited spaces. For some participants, their offices were relocated away from areas that treated COVID+ patients. Another change that affected working with patients was the requirement of wearing masks and agencies also putting up Plexiglas in spaces where individuals interacted, including on social workers' desks. Many social workers discussed how these barriers created challenges for patients. As an example, one participant stated: "I need clients to trust me. Plexiglas is a barrier between us. Face coverings mask our faces and facial expressions that are part of communication. It's a lot harder to build trust" (HR).

Despite the safety protocols in place, participants noted several examples that made them worried about contracting the virus and getting loved ones infected. This vulnerability impacted social workers' morale and feelings of safety. A few participants reported contracting the virus themselves, reporting it to the agency, conducting contact tracing, and having to quarantine. Examples that participants provided about being more vulnerable to the virus were agencies not having enough and/or adequate protection for social workers, particularly at the beginning of the pandemic, as well as needing to work with COVID+ patients. Another example of vulnerability expressed by participants was that despite the precautions taken by social workers, they remained concerned about exposure due to some patients not following safety guidelines. One participant explained in this way in reference to children not wearing masks:

It's not like I can blame them. They're not used to wearing masks and it makes them uncomfortable. Even when they put it on when I asked, a few minutes later, they're taking it off and playing with it. They're not used to it (GC).

Yet another example of social workers feeling vulnerable about their safety was an acknowledgment that people's behavior laxed over time. When COVID-19 first emerged, participants stated that everyone was hypervigilant by being more reactive and staying physically distant. But people got looser with their safety precautions over time with more knowledge about the coronavirus as well as fatigue following guidelines.

Transition to remote work

During shelter-in-place declarations, the main change implemented to create a safe care environment for many participants was to shift staff who did not need to be in-person to

telework and remote operations if possible. Telework meant having meetings and patient appointments virtually or over the phone. Participants reported many challenges that came with the transition to remote work. For one, agencies had to ensure they were being HIPPA compliant and patients' medical files were documented by the social workers and other staff doing telework. Another challenge was for social workers to have access to adequate equipment and internet while at home as well as learning how to provide teletherapy. Some participants were amazed at the transformation of their work into telehealth. Yet another challenge was social workers trying to connect patients to community resources and/or contacting outside providers for information. The outside providers working from home may not have adequate resources to work from home, which created barriers that affected patients. Participants also experienced limited access to their offices to get patient information and materials to share with patients. The last challenge mentioned by some participants was caring for children at home. One participant shared:

Some days I work from home, trying to conduct work and supervise my teenager's schooling, which has been very difficult. It is very hard to place boundaries on your kids to not disturb you. It is next to impossible, not to have your personal life spill over into your work life when you are working from home (ST).

While participants felt fortunate to still be employed during the pandemic and to be able to work from home to decrease their exposure to COVID-19, some agencies added new processes that were burdensome. For instance, one participant shared that they had to "... email them a summary of what you did broken down by the hour" (RD).

During periods when shelter-in-place declarations were lifted, remote work continued for many participants on a full-time or part-time basis as agencies were instructed to keep people physically distanced as well as based on social workers' level of comfort working in-person. Some participants took advantage of this time to access the materials they needed for teletherapy. For instance, one participant did this:

I got permission to go to my office and scanned all the things I use with patients. Converted them to pdf so I can email or share it electronically with patients. For some that don't have access, I made lots of copies so I can mail them (DP).

For a few participants, they were only able to work from home for a period of time. A participant explained in this way: "The telework for approximately 6 months was implemented but has since ended. Although a lot of social workers are fighting for the return of the telework option, our work location management is not allowing it" (VR). Even for participants who returned to work, some agencies let patients decide on the modality in which they received services from social workers and others continued with telehealth when possible with COVID+ patients.

Participants expressed concerns related to telehealth that created barriers for patients during the pandemic. Some patients missed several treatment sessions at the beginning

of the pandemic while others stayed away to wait for in-person services. One participant talked about access issues and their consequences:

The most difficult part of our job during this pandemic is communication with clients. Many clients do not have access to the internet or a device. This has led to a decrease in client care and increase in clients need for support (ST).

Some organizations have been able to loan patients cellphones and tablets so that they can participate in telehealth or navigate the resources they were being linked to. For patients who had internet and devices, they may lack technical knowledge so social workers had to teach patients or their caregivers how to access services and community resources virtually. Participants stated that patients who rely on consistency and routine were inherently resistant to change and it has been a big hurdle to figure out how to engage and make them feel comfortable to join virtual platforms for therapy and/or new programs and activities to support their behavioral health. Despite these barriers, participants also discussed how telehealth has made services more accessible for some patients. One participant talked about transportation no longer being a problem: "Telehealth has been a big blessing to a lot of our clients. A lot of our clients struggle with transportation and telehealth is something we plan to continue after the pandemic is over" (TS). Participants also noted the lower risk for COVID-19 exposure and clients preferred the virtual environment. Participants also discussed how hard they worked to ensure patient sessions ran as smoothly via telehealth as they did when they had in-person. Despite their efforts, participants noted the awkwardness of being on remote platforms. One participant explained in this way: "I wish there was a way to have digital communication with families feel more natural. So much is lost when meeting via zoom, face-time, or phone call" (HR). Some participants remarked that given the unknowns about the pandemic, they try to be adaptable and understanding.

Lastly, participants talked about having to be creative with how they utilized electronic tools to support patients and their families. Participants also reported that they tried to continue to work with patients as they did prior to the pandemic but also checked in about how the pandemic had affected them and their loved ones. During the check-ins, patients talked about their fears, anxiety, and stresses in terms of the pandemic and its impacts. Some patients who had particular difficulty dealing with the pandemic received additional services and/or counseling sessions. At the end of the sessions, participants noted the importance of discussing the next step in patients' care plan to provide some routine and reassurance for some patients.

Workload and mental health

Participants shared how busy they have been since the beginning of the pandemic and described their days as "overwhelmingly hectic" (JW), "nonstop" (HR), and "there is definitely compassion fatigue and people are exhausted" (SC) that affected their mental health and ability to work with patients. Another participant explained that "the shift to using telehealth, PPE, making accommodations related to these changes, took additional time and effort" (ST). Participants reported devoting more time to patients and

staff in terms of discussing, implementing, and overseeing safety protocols. Carrying out safety protocols when working with patients included putting on PPE, screening patients, and sanitizing everything between patients. Some had additional responsibilities such as disaster and community response to the pandemic. The number of clients also increased in terms of referrals as well as the number of COVID+ patients. Participants reported devoting more time to patient care due to their anxiety about the pandemic as well as more follow-ups. Some participants noted that their agencies reduced and/or furloughed staff, froze open positions, and/or did not replace staff after they left. Some staff may also have not shown up for work due to their infection fears and/or childcare needs. Additionally, to decrease the risk of spreading the virus, some volunteer and internship programs were discontinued. For participants, fewer staff, volunteers, and interns meant more work for the remaining staff and participants did not feel they had any choice. To wrap their heads around their new circumstances, one participant stated that their "...expectations had to be adjusted to help where needed" (DP).

In addition to the discussion on workload, many participants also expressed how stressed and emotionally drained they were for several reasons. One reason was attributed to the pandemic in general with a participant explained their reason in this way:

There is a stress that is different from any other stress because now any exposure to COVID can affect not only you, but everyone around you. People have died in this pandemic so I'm constantly washing my hands, changing out of my scrubs before I get home, and cleaning my work area (BD).

Another factor that contributed to social workers' mental health challenges was COVID-19 being a new coronavirus with so much not being known about it and the safety protocols constantly changing. For instance, one participant stated: "It was a scary time during the beginning of the pandemic, I was not sure how to deal with it myself, let alone how to educate my clients on how not to be fearful of the unknown" (JW). These reasons made it difficult for social workers to support patients. These reasons also took a toll on social workers physically and emotionally that could lead to burnout. Some participants expressed that they did not feel that their agencies cared about them while others offered mental health services and encouraged social workers to engage in self-care. Some participants indicated that they just did the best they could every day.

Preparedness and lessons learned

A few participants felt somewhat prepared for the pandemic because of their previous work experience in critical care centers, in acute care hospitals, and/or in emergency departments because they had regular disaster drills. According to one participant, the drills "...left me with an understanding that anything can happen and that we are on the front lines" (NL). However, many more participants expressed unpreparedness in several ways and offered lessons learned from this experience. Social workers stated that they never considered being called upon to work in such circumstances. One

participant suggested “more frequent discussion of what being a social worker will mean in times of crisis would be beneficial to all” (JC). Other social workers suggested being more involved in disaster planning at the city and community level to add social work perspectives as well as increase knowledge in the profession. Another suggestion was to be more aware of community resources and do more networking so that social workers could be more efficient and successful in connecting patients to needed support. Several participants also talked about wanting to know more about pandemics, the science behind them, how they have been handled in history to help themselves and patients be more realistically prepared and to better understand how the crisis might end. More specifically, participants wanted to be more knowledgeable about COVID-19, especially since they were in integrated healthcare settings so that they could better help clients understand the way the disease works, how to manage it, and its consequences.

Another lesson learned among participants was being better prepared for virtual platforms and providing therapeutic support in different modalities. For instance, a participant stated:

I wish I had learned more about virtual online telehealth options considering we have needed to adjust to telehealth. My experience with it was not the best and I feel more training and preparation on this transition would have alleviated stress and worry (SC).

Working remotely was a drastic change for many participants with various challenges. While their agencies provided technical equipment to enable participants to work from home, many experienced delays as well as difficulties setting up the equipment and learning how to use online platforms. Participants believed the transition to remote work would be smoother if the infrastructure was in place. Challenges have continued for some participants with connectivity issues and other technical difficulties such as microphones not working. One participant reported: “A lot of the staff here are feeling overwhelmed. Their already busy schedules are now compounded by having to learn new technology themselves and having to prepare to provide services via Zoom” (ST). Participants suggested tools needed to be improved and/or fixes were being done because the challenges were affecting communication between team members and their patients.

Yet another lesson learned thus far in the pandemic was having more knowledge in various areas of working with patients. Some participants wished they knew more techniques related to relaxation and coping skills. Others wanted more understanding of isolation and loneliness. Another area participants noted they wished they were better prepared for was PTSD treatments for patients admitted to intensive care.

The last set of lessons learned was related to social workers’ own mental health. Participants noted how difficult it has been to be separated from family members and friends. They have had to be creative and learn how to have safe social interactions. Participants noted that stress management has been critical to managing pandemic fatigue physically and mentally. Participants stressed the need for agencies to put in place strategies for social workers to take time for themselves. One participant put it this way:

I find that often people won't ask for help or especially in this pandemic don't have the time. Giving staff allotted time for them to take a breath and focus on themselves would help them to take care of others (JV).

Lastly, participants stressed the need for employees to have mental health services during the pandemic, despite and especially because of their busy work schedules.

Discussion and implications

The current study was designed to address the gaps identified in the literature on the experiences of social workers during the COVID-19 pandemic in integrated healthcare settings. The study captured perspectives from the initial outbreak of the virus to November 2020 when the end of the pandemic was not in sight and vaccines were not readily available.

Consistent with the literature on how disruptive the pandemic has been on medical providers (Britt et al., 2021), this study found the pandemic created numerous challenges among social workers in integrated health care. This study also found that social workers feared COVID-19 exposure and infecting loved ones similar to medical providers (Rodriguez et al., 2020). The vulnerability to COVID-19 affected their morale and feelings of safety. Barach and colleagues (2020) stated that healthcare workers needed to feel confident that they are protected from the virus in order to do their jobs. Similarly, social workers also needed to feel confident that they are protected in order to address behavioral health issues among patients. Like emergency physicians (Rodriguez et al., 2020), some social workers in this study noted the lack of PPE and inadequate protections to safely conduct their work. Lai and colleagues (2020) found inadequate resources increased apprehension, distress, anxiety, and panic among medical providers. Even with PPE, Maunder (2009) warned having to work with patients while wearing PPE may harm effective communication with patients. Specifically, for social workers in this study, the Plexiglas and masks created barriers to communication and building rapport with patients. Additionally, this study found that at the beginning of the pandemic, many agencies constantly changed guidelines on safety precautions and how to work with patients. The numerous changes were found to be frustrating and inefficient for social workers. Medical staff were also found to experience high levels of stress due to the changes (Salas-Vallina et al., 2020). Sharif and colleagues (2020) caution that the abrupt changes to safety protocols increase apprehension. Britt and colleagues (2021) found that adequate communication about the virus has been linked to lower perceptions of strain among healthcare workers.

Another area that increased apprehension among social workers in integrated health care during the pandemic was the transition to remote work in an effort to keep social workers and their patients safe. Findings from the study indicated a lack of preparedness for the move to work from home in terms of infrastructure and knowledge of telehealth. Disparities among patients as it relates to hardware and internet access must also be addressed. This study found that some social workers experienced additional documentation requirements to log their activities while working from home. The novelty of

remote work may have led some agencies to implement new reporting requirements to keep track of staff activities. Agencies need to ensure that the tracking of activities is not viewed as excessive. Among emergency medicine providers, bureaucratic activities have been viewed as excessive and a stressor (Schneider & Weigi, 2018). Despite social workers' apprehension, telehealth had its benefits such as allowing social workers to provide vital support for patients with counseling and support groups. Telehealth can be an effective platform to increase mental health services access (Barach et al., 2020) as well as alleviate isolation (Cox, 2020). Technology can also help to monitor individuals and relieve caregiver stress (Cox, 2020).

Providers in integrated health were experiencing stress and burnout before the pandemic (Lin et al., 2019; Rodriguez et al., 2020; Rotenstein et al., 2018). Among health-care workers, the pandemic has provoked distress, apprehension, anxiety, and depression (Lai et al., 2020; Sharif et al., 2020). Consistent with literature that virus-related demands have been found to increase mental health strain among emergency medicine personnel (Britt et al., 2021), this study found similar effects on social workers. Participants reported their workload was dramatically increased due to the pandemic with more patients in crisis, patients in need of more care and follow-up, agencies being understaffed, and other-virus related demands. Increased job demands require continuous mental, emotional, and physical efforts that can lead to strains (Britt et al., 2021). The workload of social workers can be exhausting and lead to burnout, job dissatisfaction, and increased intent to leave employment.

To be effective in addressing emotionally charged situations in integrated healthcare settings, social workers must be highly proficient in managing their own emotions (Nelson & Merighi, 2002) and be emotionally accessible to patients (Kahn, 1993). Harmful consequences may occur if social workers' own emotions are ignored and/or controlled (Nelson & Merighi, 2002). This responsibility, particularly during high intense times such as a pandemic can be physically and emotionally exhausting (Kahn, 1993). Coping strategies have been found to reduce strain during pandemics (Cai et al., 2020). While social workers are keen on helping patients to develop coping strategies during the pandemic, as found in this study, social workers need to be reminded that they also need to adopt coping strategies for themselves. Integrated healthcare agencies must prevent social workers from burnout and/or leaving their jobs by reducing workload and other burdens in an effort to maintain an adequate workforce. Barach and colleagues (2020) suggested reducing barriers and improving workflow to document in electronic medical record systems. Agencies can provide social support for social workers that may help with combatting emotional exhaustion (Nelson & Merighi, 2002). During the SARS pandemic, social support was found to reduce psychiatric symptoms among hospital employees (Chan & Huak, 2004). Supervisors can provide psychological support by giving social workers positive feedback (Britt et al., 2021). Management can encourage and make available counseling services as well as promote self-care for social workers. Lastly, social workers should be reminded to seek social support from co-workers (Britt et al., 2021), family, and friends.

According to Nissen (2020), the pandemic has awakened the meaning of being prepared as well as created challenges and opportunities. Findings from this study revealed

the unpreparedness of social workers during the COVID-19 pandemic in integrated health care. Rather than reacting to current events, Nissen (2020) posited the social work profession must take part in preparing for the prevention and addressing social problems of the future. The social work profession can do better in educating social workers about the history of pandemics, the tolls that they take on vulnerable populations. Similarly, this study found that social workers believed having knowledge about disaster planning, pandemics in general and COVID-19 specifically, would help them and their working with clients to better cope. Social work programs may consider having a course on disaster planning, its effects on mental health of providers and patients, and effective interventions. In terms of clinical practice, guidelines are also needed for effective online therapy. With macro practice, social workers have taken a small part in disaster preparedness efforts (Zakour & Harrell, 2004). Nissen (2020) recommended that the social work profession plays a major role in the planning and preparation for future pandemics in partnership with other professions to create new solutions that are more equitable as the new normal.

Limitations of the study

The present study's limitations and recommendations for future research in this important area of work should be noted. Qualitative methods used in this study are not and were not intended to be generalizable. Future studies that use other methods and increased rigor are needed to ensure generalizability. The study is limited to perceptions of social workers during the early months of the pandemic. A follow-up study may benefit from a more comprehensive understanding. Given the length of the pandemic and the unknown effects, longitudinal studies are needed to further comprehend social workers' experiences in general and working with patients specifically. Participants were based on the research team's network so there is a potential for selection bias. Factors limiting the ability of social workers to participate include individuals with high workloads that did not have the time to take part in the study. This study relied on social workers self-reporting of their experiences during the pandemic. Although self-reported measures are valid and stories of experiences are vital for understanding the phenomena, future research can provide additional objective assessments such as number of hours worked, size of caseloads, number of social workers infected in integrated healthcare settings, number of people who resigned, and capturing social workers' stress by having them wear sensors. Rodriguez and colleagues (2020) found providers in integrated health were already stressed and burned out before the pandemic. Lastly, social workers in this study did not discuss their workload prior to the pandemic. A follow-up study could compare social workers' workload before, during, and after the pandemic to assist leadership in the management of social workers' and inform workplace well-being.

Conclusion

Despite the limitations, the findings of this study offer insight into how social workers dealt with the pandemic in integrated health care. Although studies of the pandemic

and the impact on integrated healthcare are increasing (Britt et al., 2021; Lai et al., 2020; Salas-Vallina et al., 2020; Sharif et al., 2020), little is known about the experiences of social workers in these settings. This study found that while many social workers believed their agencies well navigated the COVID-19 pandemic, they nonetheless feared contracting the virus given the many unknowns at the beginning of the pandemic. As a way to protect staff and patients, many agencies transitioned to telehealth and remote work but social workers in this study experienced challenges with documentation, HIPPA compliance, and access to the internet and equipment. The workload was found to be overwhelming and affected social workers' mental health at the beginning of the COVID-19 pandemic. Lastly, this study identified lessons learned by social workers that could be implemented for future disaster preparedness such as practicing disaster drills; participating in disaster planning at city and community levels; being aware of community resources during a crisis; having knowledge about pandemics and other disasters; learning about different modalities to provide therapeutic support; knowing how to work with patients on issues and strategies related to crises; and addressing their own mental health so they can care for patients. The experiences of social workers in integrated health care during the pandemic were consistent with the existing literature on medical providers. While it may be assumed that providers in the same settings would have similar experiences, this study contributes the literature by adding that of social workers. This perspective is crucial given the importance of behavioral health for patients' well-being. This study also adds to the literature in finding that social workers were mentally and physically exhausted during the beginning months of the pandemic. Findings may inform social work practice in integrated healthcare settings as well as offer guidance for proactive preparedness for similar crises in the future.


Research ethics

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