

Staff wellbeing during the COVID-19 pandemic

Guidance for organisations

During the COVID-19 pandemic we are faced with a potentially life threatening situation to some of the population with many others being unwell. This is a situation of ongoing threat sufficient to be defined by the World Health Organisation as a disaster: “ a severe disruption, ecological and psychosocial, which greatly exceeds the coping capacity of the affected community.” Whilst there is very little research on the mental health impact of pandemics, there are emerging lessons from China’s covid-19 management, some data from the SARS outbreak and many other principles of good practice from other disasters. The particular ongoing nature of the threat and the extent of its impact pose particular challenges.

This guidance and associated framework for recommendations is in response to the COVID-19 outbreak, is based the evidence and it is hoped it will help organisations to promote the psychological health of their workforce.

What we might expect

During the immediate outbreak, China found that 75% of healthcare staff report symptoms of traumatic stress, 50% depression and 44% anxiety. Such immediate distress is expected in large numbers and can be considered a normal response. It is a minority of staff who are resistant to distress during this phase. Most, people, do recover their peace of mind after the threat passes. For a smaller percentage this can persist over time. In the two years after SARS staff burnout did increase significantly.

Some of this variance is predicated on things the organisation can do:

1. Protection from perceived unnecessary risks.
2. Prioritising staff’s physical safety.

3. Adequate training and support to carry out their role.
4. Showing staff they are of value in themselves.
5. Having a clear steer and guidance whilst allowing staff autonomy.

There are some personal risk factors for developing significant immediate distress or later ongoing problems that needs specialist help:

1. Having pre-existing mental health problems.
2. Having pre-existing psychological trauma or lack of support (including domestic abuse).
3. Suffering a bereavement directly or indirectly from the outbreak.
4. Being significantly ill during the outbreak (or a loved one).
5. Being separated from family (because of work or because of isolation/quarantine).
6. Losing an income.

Common fears of staff during a pandemic

- Many Healthcare Staff do not worry significantly about catching the disease themselves.
- They do worry about passing it on to their family, some of who may be in high risk groups.
- They worry about passing it on to vulnerable patients.
- They can be concerned about managing uncooperative patients.
- They worry about not having the right equipment to help people.
- They are concerned they won't be able to do a good job.

The traumatic nature of an epidemic

- It disrupts health and communities more than any other major disaster.
- It impacts on the health of staff too and therefore limits capacity to manage the scale of an outbreak.

- The scale of the demand on healthcare may mean that people do not get the usual standard of care and treatment, or staff have to make difficult decisions about who gets what treatment.
- This may mean that staff feel compromised in their professional ethics leading to 'moral injury', a conscience based reaction that leads to shame or anger.
- People may not be able to offer comfort to relatives or patients as they die because of social distancing.
- Infection control may mean that funerals are small or cannot take place in person.
- The scale of the deaths means that it will affect everyone and therefore the capacity to offer support when grieving oneself.
- There is little certainty and the threat is going to continue for some time.
- Sustained threats are often more challenging as it allows for threat based responses to become chronically embedded as the new 'normal'.
- The media is full of scary stories and it is hard to escape from reminders.
- Staff's usual networks of alliances and social buffers in times of stress may be broken by volume of work, redeployment or sickness.

These factors can make the trauma of a pandemic harder to deal with than many other major incidents, disasters, mass casualty events or bereavements. For this reason a trauma informed approach to wellbeing during the pandemic would be recommended. This is a practical, value driven, system wide approach to the impact of trauma. It appreciates people's responses in the environmental context in which they arise; seeks to promote physical and psychological safety; considers potential inadvertent harms from actions intended to be helpful; and sets up relationships that empower and value people.

The task of the organisation

Principle one: To avoid duplication of work and fragmentation of services, the range of psychological support options needs to be coordinated with multiple partners across the system.

Principle two: The physical safety and health of staff needs to be the priority UNTIL THE THREAT HAS PASSED for that individual person.

Principle three: Informal support, relationships and connectedness needs to be fostered.

Principle four: the system needs to be flexible and needs led to respond in a timely way to differing needs.

Principle five: empathy and normalisation in leaders are the cornerstone of a resilient system.

Principle six: strengthen natural supports of staff and capitalise of their knowledge, foster empowerment and value their resourcefulness.

A systemic stepped model

Prevention of overwhelming distress or ongoing disorder in the first stages of the epidemic

- Adequate infection control in place in line with WHO/ government advice.
- Give staff accurate information from credible sources.
- Provide a place to rest or live near the hospital, where staff can isolate themselves from family if they are with infected patients.
- The organisation can arrange for meals to be provided whilst on shift and possibly daily living supplies for staff.
- Training delivered on managing the disease in people who use the services.
- Training delivered in psychological first aid to support each other.
- Peer support networks to be facilitated.

- Provide confidential spaces with people to turn to for informal support that is easy to access and in the moment.
- Allowing personal circumstances and concerns to be considered in deployment.
- Online solutions available for training and support.
- Collaboration with other agencies on support options.
- Specialised advice for leaders on the potential impact of their decisions from mass trauma experts.
- Trained trauma supervisors for those supporting the wellbeing of frontline staff.
- Put in place screening and monitoring for ongoing distress.

The management of severe distress

- It is important to normalise most reactions.
- For ongoing or debilitating distress, there needs to be clear and confidential referral routes for psychological therapy.
- Screening should happen over time and prompt referral to specialist services with clear pathways for when this should happen.
- Most demand will increase after the immediate threat has passed or people start to experience or witnessing deaths.
- Supervision and training of therapists who conduct therapy needs to be in place before the demand increases.
- This therapy should be provided by existing services, perhaps with enhanced staffing if possible.
- Therapy should follow NICE guidance where appropriate and matched to the needs and preference of each person.

Immediate responses to support staff in the acute phase

1. The operational debrief

WHY: This is an opportunity to ensure the epidemic is being properly managed. It is about processes and lessons (repeated as often as needed). Do we have

enough supplies, staff, what's working, what is working less well, etc....Who did what and how did it go. What is needed for the service to operate effectively. This needs documented and for the effectiveness of the organisational response to be discussed in order to identify lessons learned and good practice and whether any revisions to the Plan are required. A local debrief immediately after the incident allows staff to feedback on their department's performance and the overall response. This also gives staff information that can resolve the development of emerging ideas, beliefs or emotions that could lead to ongoing psychological issues.

WHEN: A hot debrief can be held regularly during the epidemic, but definitely once the stand down process is complete and could involve all key staff involved in the response.

HOW: The debrief procedure is a constructive review process which should be undertaken in an open, honest, and "no blame" atmosphere.

All issues discussed during the local debriefs should be passed on so that they can be incorporated into the overall debrief and post-incident report.

The debrief could:

Thank staff involved for their contribution

Highlight issues and problems with procedures

Allow staff to provide their perspective on management of the incident

Identify good practices and procedures

Identify any long-term follow-up needs of staff

FOLLOW-UP: Any issues or concerns raised here could be investigated and reported back on at the 'Cold debrief' which should take place after the epidemic is over.

2. Informal psychological support

WHY: As social animals we can be helped to regulate the impact of threat by the people around us. We can use our networks and compassionate motivation to connect with people and by doing so lessen the impact of any incident or stress. This form of support and debriefing is best separated from operational issues, because it is for the purpose of the wellbeing of staff. To

ensure they have what they need to continue to tolerate their role. Space and time for emotions to be expressed if wished without judgement.

WHEN: Ongoing but particularly in the first hours, days or weeks and afterwards if any changes are noticed in how staff are functioning.

HOW: make an effort to ask colleagues how they are and create space and time for a conversation, 'banter' and slowing down after a busy shift. **Formal psychological debriefing is not recommended by the evidence.** This is anything that gets staff together at an appointed time to talk about their feeling after an incident. It is also recommended that behavioural reactions and emotions be understood and normalised rather than sending people for therapy or counselling. Systems should be set up for staff to support each other, as they are the valued networks and connections that can help people feel more regulated.

FOLLOW-UP: ask what they would like. Don't leave colleagues isolated.

3. Information on reactions and support (Psychoeducation and communications)

WHY: to give clear messages so people know what reactions are typical and how to help themselves and others.

WHEN: in first days and then again after a month.

HOW: usually written material or videos or online links. This should address a full range of reactions, what people can do to help themselves, how to support others who are affected, what to look out for that might indicate people need additional or specialist support.

FOLLOW-UP: in the case of all mass casualty event it is good practice to followup with screening after one month and at regular intervals.

7. Early psychological intervention (Psychological first aid)

WHY: to reduce immediate distress and promote adaptive coping, problem solve with practical issues and feel connected with others.

WHEN: multiple sessions should be available flexibly and linked to places where people may be, eg, staging areas, feeding stations etc.

HOW: The emphasis on normalising a whole range of reactions, especially those within weeks of the event. Stages: Protecting from further harm; Opportunity to talk without pressure; Active listening; Compassion; Addressing and acknowledging concerns; Discussing coping strategies; Social support; Offer to return to talk; Referral on to other services. This is delivered by a network of staff peer supporters who have had training and are supported by experts in this role.

FOLLOW-UP: yes if the person wants to take up.

8. Telephone support

WHY: a source of confidential support, listening and advice out of hours.

WHEN: these services are available 24 hours a day 7 days a week and can be accessed via telephone, email or other social media platforms (please see websites).

HOW: Open access to 24 hour help through helplines such as the Samaritans, Red Cross or other services. The services offer a trained listening ear to help you talk about your experiences and think about how best to cope.

FOLLOW-UP: the person can ring as often as required.

9. Urgent mental health team support

WHY: to help you or someone you care about if they are in immediate need to psychological help. The incident may have made a pre-existing mental health problem worse, or they may be feeling that they may harm themselves.

WHEN: at any point – such services are available 24/7.

HOW: Services available may include out of hours home treatment via crisis teams that are aimed at support for people in extreme distress. Liaison teams can see people who have people physically injured and ended up in acute hospitals or Accident and Emergency as a result of the event. People may be

offered a telephone assessment or a face to face meeting with a mental health professional who will assess immediate psychological needs and make a plan with you. They will want to make sure the person is safe, which may include referral for psychiatric admission. Some organisations may have specialists in mental health working alongside their occupational health teams that staff can access.

FOLLOW-UP: Once assessed, and depending on the outcome, the person may be followed up by the mental health practitioner who assessed them or by their family doctor.

10. Breaking bad news/ Discussing death

WHY: to give clear messages about the outcome of the illness, whether that is death or disability. To support the person given the message whether it is the person injured or their family member.

HOW: Being clear about the message that is given. Supporting someone to understand the impact of the news and tolerate the grief. Allow someone space to react without services/ staff panicking about those reactions. Listen empathically, don't judge. Give normalising information where possible and be alongside someone as they absorb the information and adjust. Remind them of their options for help and support. Help them find and access support from others and check what they have understood. Help them consider practical things that need attention.

WHEN: as soon as possible after the outcome of the illness is clear.

FOLLOW-UP: yes if possible. It may be the person who has broken the news or it may be possible to keep a list of people involved in a serious incident that can be follow-up afterwards. The follow up services for psychological care need to be visible and marketed most intensively for the first six months but for at least two years afterward the epidemic. Access to services and the impact on the community may be life-long.

Longer term actions to support staff in the pandemic's recovery phase

1. Screening

WHY: to detect people affected by the events whose reactions are not easing off with support or time and who may need more help in resolving the impact. To pick up specific post event psychological reactions such as depression, post traumatic stress disorder, dissociation.

WHEN: useful only after the threat is over because many reactions are common during the outbreak but resolve better without active intervention. Screening can take place any time after an event, even up to many years later.

HOW: usually via questionnaires or structured interviews. However this needs to be accompanied by some qualitative information that asks the suitability of therapy and what kind of support the person thinks would be acceptable.

FOLLOW-UP: if screening indicates an ongoing problem with symptoms or coping or functioning or risk then more specialist or intensive support should be offered without having to wait for more than a couple of weeks.

2. Psychological therapy/treatment

WHY: it is a method provided by a trained practitioner that helps you understand and cope with your worries and bad experiences differently. It may be one to one or in a group. It usually involves talking, although there are other methods eg art, eye movements. It usually involves a series of regular appointments.

WHEN: if screening indicates it then it is offered at some point four weeks after an event.

HOW: there are various methods but NICE recommends 'trauma focused cognitive behavioural therapy' (CBT-t) or 'eye movement desensitisation and reprocessing therapy' (EMDR) for many post traumatic reactions.

FOLLOW-UP: people should know who to contact or via their GP if problems persist or recur.

3. The operational and organisational learning lessons

WHY: report the findings of any investigation, the lessons learnt and the actions taken to improve the system's response for the future.

WHEN: usually as soon as possible after the epidemic.

HOW: include people in hot debrief session in conversation as above.

FOLLOW-UP: All the issues raised in the earlier sessions could be included in the post-incident report which should be completed after the epidemic is over. The post-incident report, including recommendations for improvement in the Incident Response Plan, can be produced and circulated widely to assure staff.

Unhelpful responses

Not allowing or enabling individuals to be active in their own 'recovery'

Interrupting the usual support processes in deference to those organised or provided – we should enable the natural support processes as far as possible. Like a Lifeboats, most systems or individuals will find ways to self-right.

Lack of validation/no support offered.

Going straight back into busy roles and business as usual.

Management interventions aimed at exploring responsibility and unpicking events have been found to be linked to increased self blame/negative appraisal.

Not being given a choice re attending group debriefing or being told it is mandatory.

Placing people into a group, who have completely different experiences of the incident, than other members.

Lack of training or competency in early psychological interventions.

Feeling forced to talk about things during the crisis.

Having your reactions pathologised when in fact a range of emotions are normal in abnormal circumstances.

Getting staff together for the purpose of talking about their emotions to prevent the development of mental health problems (or other one off group based intervention) is **not** recommended by nice.

Looking after ourselves

Turning up for work during such time requires us to manage our fears and trust that our leaders will be making wise decisions about our safety and contamination. Extreme emotions are normal during abnormal times. The widespread nature of the problem might rally more people to collective positive action. Sometimes it can make people irritable, controlling, avoidant, needy or 'hard'. The things that affect us the most may not make sense to us.

Stay grounded in your motivation to do a job as well as is possible under the circumstances.

Be forgiving of others.

Keep well informed and well connected.

Raise concerns and ideas for action.

Informally support each other emotionally.

Focus on the things you can control rather than those you can't.

Find safe people to talk through your worries.

Use the same resources and advice for yourselves that you give others.

Rest and slow down when you can.

Smile when you can.

And breathe...

Action planning

The following is a list of prompts for organisations to consider. It will be useful to outline actions for each of these, outlining any gaps and risks, mitigating actions against these and detailing who is responsible for each, ensuring adequate delegation and coordination:

<i>What are you doing to keep your staff safe and well in line with guidance?</i>
<i>What do they need to do their role?</i>
<i>What mechanisms are there for staff feedback and ideas on operational issues?</i>
<i>How can you facilitate informal staff support and networking?</i>
<i>What clear early messages are you giving to staff and are communication routes thorough?</i>
<i>How are you maintaining established support systems and wellbeing services?</i>
<i>How are you preparing staff to monitor their wellbeing over time?</i>
<i>How are leaders and managers supported to be empathic and non-judgemental of the range of reactions?</i>
<i>What information do you have that lets people know what reactions to expect and how they can cope under specific circumstances?</i>
<i>How are you governing adherence to the evidence base on wellbeing?</i>
<i>How are you ensuring co-ordination of efforts around wellbeing (including across agencies)?</i>
<i>What pathways do you have for more intensive or specialist psychological support for those who need it? and ensuring these are sustained over a 3 year time period?</i>
<i>How can you manage staffing so that staff have rest time now, rotation away from high stress roles and fewer demands after the crisis?</i>
<i>What can you do to develop capacity in psychological first aid and peer/mutual support?</i>
<i>What use are you making of online solutions and technology in the above?</i>
<i>What trauma expertise can you draw on or develop to provide scaffolding to support the leaders and staff supporters in their efforts?</i>
<i>How can you show staff they are valued and appreciated?</i>

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Guidance for
Psychological Profess

PREPARATION PHASE	ACTIVE PHASE		RECOVERY PHASE
Anticipatory anxiety	Heroics and surge to solution	Disillusionment and exhaustion	Recovery and long term psychological impacts
<p>Planning may happen at a high level in a rapid timeframe leading to anticipatory anxiety about the unknown.</p> <p>With limited time to plan, and limited input into the preparation phase, many staff may not report feeling 'prepared' for the outbreak.</p> <p>Many UK Health Trusts have now passed through this phase.</p>	<p>Increased camaraderie as staff cross boundaries and work together.</p> <p>Sense of rising to a challenge.</p> <p>Staff may respond on instinct and are more prone to error. They may lack the headspace to see all options.</p> <p>Frustrations and role confusion as people try to adapt quickly within current system design.</p> <p>Staff witnessing things they have never seen before and feeling out of control.</p> <p>Disagreement between groups over sense of urgency.</p> <p>Staff lose usual boundaries over working hours and breaks and start to over-work.</p> <p>Work-life tensions arise as family life also becomes unsettled.</p> <p>Social norms and niceties slip and behavioural responses may cause difficulties for others.</p> <p>Focus on 'getting things done' which may lead to poor communication and silo working.</p>	<p>The period of highest psychological risk.</p> <p>Staff are in 'full go mode' with high levels of adrenaline and on 'automatic pilot'. They may then experience sudden exhaustion.</p> <p>They may neglect physical and psychological self-care as they feel it is not a priority.</p> <p>Moral distress and injury are a risk as healthcare becomes limited and people are unable to act or respond within their own moral or ethical code and death and dying may not be handled in the way it usually is (with family etc.).</p> <p>Staff may begin to feel emotionally disconnected from the work, experience compassion fatigue, and may engage in avoidant or unhelpful coping.</p> <p>Tensions at home and within the wider family may over-run work life.</p> <p>Stress has a cumulative effect and smaller things trigger reactions.</p> <p>Staff with pre-existing vulnerabilities are at higher risk of crisis and suicidality.</p>	<p>Staff have time to start to reflect.</p> <p>Most staff will feel able to cope successfully using their own preferred style, individual resources and social support. Many may be changed in a positive way, experiencing personal development, and post traumatic growth.</p> <p>Some may experience intrusive thinking about what they 'should' have done differently and shame or guilt. Dissonance with a 'heroes' narrative may make this harder to disclose problems and may exacerbate distress.</p> <p>Others may feel differently about their job and experience resentment towards individuals and towards the organisation.</p> <p>Individual difficulties have wider family and social impacts which may further exacerbate these longer-term impacts.</p> <p>Certain staff may be at risk of chronic psychological difficulties (including but not limited to burnout and post-traumatic stress).</p>

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