

EDITORIAL

Supporting Hospital Staff During COVID-19: Early Interventions

During a pandemic, hospital staff are at increased risk of a range of adverse mental health outcomes [1]. There are factors during the current COVID-19 pandemic that are likely to exacerbate this risk including concerns about personal safety due to exposure and lack of personal protective equipment, high levels of fatalities amongst medical staff and patients and moral injury. Most people are resilient and over time will cope with these stressful and challenging experiences. Some staff, however, will develop anxiety, depression and post-traumatic stress disorder (PTSD) [2].

There has been a rush in many countries to offer psychological support for hospital staff. There is evidence, however, that certain types of early intervention may be unhelpful and could even worsen mental health outcomes [3]. The quantity, and quality, of current research in this area is limited, and most research to date has focused on early interventions after a single major incident and after the crisis has passed. There is also limited knowledge on providing support at a time when those offering support are also exposed to a shared threat. Therefore, we must extrapolate from current evidence what might be most helpful.

The response to ongoing high stress should aim to support coping, foster resilience, reduce burnout and reduce the risk of developing mental health difficulties. The following guidance is collated from research, best practice guidelines and expert clinical opinion [3–7].

The basic physical needs of staff should be met, including safety (appropriate access to personal protective equipment), food and hydration, rest and sleep. Support staff to take breaks and attend to self-care. Role modelling of these behaviours by senior staff will be important.

It is important to provide high-quality communication and accurate information updates to all staff. Brief staff in an open, honest and frank way so they are best prepared for what they are going to face and what they might be asked to do.

Rotate workers from higher-stress to lower-stress functions. Implement flexible schedules for workers who are directly impacted or have a family member affected by a stressful event.

Provide training not only on the clinical skills required to deal with COVID-19, but also on the potentially

traumatic situations that staff might be exposed to including honest communication of the facts, developing skills to cope with these and awareness of potential mental health consequences. Evidence of the benefits of these interventions being delivered pre-trauma exposure appear promising, so are likely to be particularly important for new staff being mobilized to help with the response, such as final year medical students and student nurses, and those that are being redeployed from other locations or specialities.

Respond to staff feedback on what is, and is not, helpful. Set up regular feedback mechanisms so messages can reach management quickly. Make sure to act on feedback and where this is not possible, communicate why this cannot be done.

Pay attention to staff who may be particularly vulnerable due to pre-existing experiences or mental health issues, previous traumas or bereavements, their own physical health, or concurrent pressures and loss. Think about how to best monitor these staff and put extra support mechanisms in place for them.

Encourage staff to use social and peer support. Staff may feel guilty or not want to burden others, particularly their family, so peer and management support should be maximized at work. It is not enough just to have good support systems in place, staff need to actively use them. Evidence suggests that when a worker has the informal support of their peers following traumatic exposure, they are less likely to need formal intervention. Inexperienced workers should be partnered with more experienced colleagues. Such ‘buddy’ systems help to provide support, monitor stress and reinforce safety procedures. The efficacy of peer interventions does not come from having a single trauma-informed or trained staff member, but from a camaraderie and sense of common fate that can emerge from a shared experience of trauma.

Facilitate team cohesion and strong supportive links between team members and managers. Allow staff time to be with and support each other and encourage activities and discussions also unrelated to COVID-19 where possible. It will be important for managers and team leaders to role model a caring and cohesive team approach—‘we’re all in this together’. Evidence shows that cohesion between personnel is highly correlated with mental health, and that the resilience of a team may

be more related to the bonds between team members than the coping style of any individual.

Provide opportunities for staff to talk about their experience to enhance support and social cohesion. This can occur at the end of shifts or at significant points in the response. This may take place individually between a staff member and manager or supervisor, or in teams of people who work together. These sessions should not involve anyone being mandated to talk about their thoughts or feelings. It is important for organizations to provide these opportunities, but for staff to be free to decide whether to attend. If offered, these sessions should be provided during a staff member's shift (not afterwards) so as not to encroach on rest and recovery time.

Continue to actively monitor and support staff after the crisis begins to recede. Where necessary, refer on for evidence-based psychological treatment.

Have a low threshold for referring staff members to well-being or psychology services. Managers and staff should know who to contact and how. If formal psychological intervention is indicated after an appropriate assessment, options include generic cognitive-behavioural therapy (CBT) and trauma-focused CBT for acute stress disorder. After 1 month, refer to psychological services if staff are showing signs of PTSD.

Psychological interventions should be evidence-based. The people delivering any psychological support should be appropriately trained, competent and have clinical supervision. Establish clinically appropriate 'supervision of supervision' structures.

Some forms of early intervention should be cautioned against, as evidence indicates they may be harmful.

Do not offer psychological debriefing (PD), critical incident stress debriefing (CISD) or any other single session intervention which involves mandating staff to talk about their thoughts or feelings. There is evidence that these interventions may be ineffective or even increase the likelihood of developing PTSD.

Do not offer non-specific training programmes such as 'mental strength' training as these are not beneficial for reducing mental health problems or PTSD and are likely to have high dropout rates.

Do not rush to offer formal psychological interventions too soon without careful assessment, including active monitoring. Although well-intentioned, intervening in people's natural coping mechanisms too early can be detrimental.

Do not offer any unproven approaches to psychological treatment. Any psychological intervention should be provided by an appropriately qualified and supervised clinician, at the appropriate time.

This guidance is not an exhaustive list of recommendations but is intended to inform planners, managers and team leaders of the organizational and psychological processes which are likely to be helpful, or unhelpful,

in supporting staff during the COVID-19 pandemic. Research is needed to evaluate the effectiveness of any interventions in the longer term.

This guidance has been produced by the COVID Trauma Response Group, a team of specialist trauma clinicians and researchers. The working group is coordinated by staff at the Institute of Mental Health at University College London working in conjunction with colleagues in clinical, academic and social care settings across the UK.

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