

## Guidance for planners of the psychological response to stress experienced by hospital staff associated with COVID: Early Interventions

The following guidance is collated from research, best practice guidelines and expert clinical opinion. This guidance is not an exhaustive list of recommendations but is intended to inform planners, managers and team leaders of the organisational and psychological processes which are likely to be helpful, or unhelpful, in supporting staff during the early stages of the response to COVID.

Staff may experience a range of normal responses including anger and irritability, enhanced anxieties, low mood, increased alcohol drinking, smoking and eating, sleeping problems, and burn out. Broadly speaking, the aim of the response to active ongoing stress is to foster resilience, reduce burnout and reduce the risk of post-traumatic stress disorder (PTSD).

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. Therefore, we have to extrapolate from this what might be most helpful whilst a crisis is still ongoing. This guidance is also informed by recent research and expert opinion emerging on the COVID crisis. Research will be needed to evaluate the effectiveness of any interventions in the longer term. All resources are available at [www.traumagroup.org](http://www.traumagroup.org).

### Do's

- ✓ Ensure that good quality communication and accurate information updates are provided 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. Partner inexperienced workers with their more experienced colleagues. Such 'buddy' systems help to provide support, monitor stress and reinforce safety procedures. Implement flexible schedules for workers who are directly impacted or have a family member affected by a stressful event.
- ✓ Do ensure that the basic physical needs of staff are being met including sleep, rest, food and safety (including appropriate access to personal protective equipment). Do support staff to take breaks and attend to self-care. Role modelling of these behaviours by senior staff will be important.
- ✓ Do provide training 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 issues. 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 mobilised to help with the response, such as final year medical students and student nurses.
- ✓ Do be flexible in supporting needs and 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 can't be done.
- ✓ Do pay attention to staff who may be particularly vulnerable. This may be because of pre-existing experiences or mental health issues, previous traumas or bereavements, or concurrent pressures and loss. Think about how to best monitor these staff and put extra support mechanisms in place for them.
- ✓ Do encourage staff to use social and peer support. It's not enough just to have good support systems in place, staff need to actively use them. Staff may feel guilty or not want to burden or distress others, particularly their family, so think about how peer and management support can be maximised at work. Evidence suggest that when a worker has the informal support of their peers following traumatic exposure, they are less likely to need formal intervention. The efficacy of peer interventions does not

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come from having a single trauma-informed or trained staff member, but rather comes from the camaraderie and sense of common fate that emerges from a shared experience of trauma

- ✓ Do facilitate team cohesion and try to foster 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 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.
- ✓ Do consider more naturalistic forms of ‘debriefing’ or ‘demobilising’ 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. This an opportunity for staff to talk about and process their experiences and can enhance support and social cohesion. These sessions should not involve anyone being mandated to talk about their thoughts or feelings. It is important for organisations to provide these opportunities, but for staff to be free to decide whether to attend or not. 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.
- ✓ Do understand that most people are resilient and will manage to cope with stressful experiences. Nevertheless, do have a low threshold for referring staff members to Wellbeing or Psychology Services if you are concerned about them. Make sure you know who to contact and how.
- ✓ Do ensure that people delivering any psychological support are appropriately trained, competent and have clinical supervision. Establish clinically appropriate ‘supervision of supervision’ structures. Ensure that any psychological interventions are evidence-based.
- ✓ Do continue to actively monitor and support staff after the crisis begins to recede. Where necessary, refer on for evidence-based psychological treatment.

### Don'ts

- ✗ Don't 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.
- ✗ Don't offer non-specific training programmes such as ‘mental strength’ training as these do not have a beneficial impact on reducing mental health problems or PTSD and are likely to have high dropout rates
- ✗ Don't rush to offer direct psychological interventions too soon. Although well intentioned, intervening in people's natural coping mechanisms too early can be detrimental. NICE guidelines advocate ‘active monitoring’ during the first month after a major trauma before intervening. However, if staff are showing signs of stress after this time, do refer on to Psychological Services.
- ✗ Don't offer any unproven approaches to psychological treatment. Any psychological intervention should be provided by an appropriately qualified and supervised clinician, at the appropriate time.

## About the COVID trauma response working group

The COVID Trauma Response Working Group has been formed to help coordinate trauma-informed responses to the COVID outbreak. We are made of psychological trauma specialists, coordinators of the psychosocial response to trauma and wellbeing leads at NHS Trusts. The working group is being coordinated by staff at University College London and the Traumatic Stress Clinic based at St Pancras Hospital in Camden and Islington NHS Trust. We are very grateful to our clinical and scientific colleagues in other NHS trusts and universities who are contributing to this work. We hope that this work is helpful to our colleagues involved in the care of patients affected by the COVID pandemic.

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