What healthcare leaders need to do to protect the psychological well-being of frontline staff in the COVID-19 pandemic

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Delivery of high-quality care is dependent on staff with the right skills, experience and motivation. National Health Service (NHS) staff are performing in extraordinary ways while being scrutinised by a watchful media that currently describes them as heroes and a presently enthusiastic public that regularly claps them.

Nonetheless, it is inevitable that exposure to significant stressors will lead to some experiencing mental health problems. Like the rest of the population, staff are likely to be anxious about the future while contending the challenges of societal shut-down, which makes it difficult to destress by having a drink with a friend, playing sport or being part of social gatherings. Some will no doubt worry about their exposure to COVID-19 that could directly endanger them and their families. News of unexplained higher mortality in BAME groups and inadequate hospital supply chains for personal protective equipment (PPE) may also cause disquiet.

At work, staff wearing burdensome PPE will find that patients die despite their best efforts. Distress resulting from feeling that a life could have been saved if only you knew more, had better equipment, experience or training, or if there were not so many patients to deal with may result in 'moral injury'. This describes the suffering that occurs when circumstances clash with one's moral or ethical code.[1] Our understanding of moral injury remains somewhat immature, but many people with moral injuries develop mental illnesses such as depression or post-traumatic stress disorder (PTSD).[2]

Leaders will know that protecting staff mental health forms part of the legal duty of care.[3 4] However, 'presenteeism'[5]—people being at work but operating suboptimally because of health complaints—is a much bigger problem than absenteeism. In safety critical healthcare, making poor, slow or incorrect decisions can have disastrous consequences.

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Preventive medicine provides a useful model for healthcare leaders. First, prevent ill-health onset (primary prevention); next, prevent progression by identifying and intervening against early indicators of impending ill-health (secondary prevention); and last, when illness occurs, provide early treatment to optimise rapid recovery (tertiary prevention).

With the above model in mind, leaders must provide staff with frank information about what lies ahead while simultaneously positively emphasising how important their roles are and the organisation's honest commitment to support them. This helps individuals make informed choices about their role suitability and to prepare cognitively, emotionally and practically. Additionally, provision of coping skills training ('psychological PPE') may help foster resilience, although evidence that it prevents longer term mental ill-health is lacking.

Stronger evidence shows that reinforcing social bonds, between colleagues and supervisors, is highly protective of mental health.[6] Leaders should 'buddy up' shift staff and ensure end-of-shift reviews are conducted. Psychological debriefing techniques should not be used as they have been conclusively found to be unhelpful and may cause harm[7]; unsurprisingly, the National Institute for Health and Care Excellence (NICE) warn against their use. Staff require basic needs met: shift patterns, rest areas and suitable safety equipment, and leaders should ensure that up-to-date and accurate information on local and national supportive services are well advertised, using media such as posters, emails and handouts. While many 'wellness' approaches are in vogue, such as mindfulness or virtual yoga—and unlikely to cause harm—evidence of benefit is often slim.[8]

Commonly, people developing mental health difficulties fail to seek help. Secondary preventive measures require supervisors, and trained peers, to be alert for early signs of distress. Leaders should ensure that supervisors can have psychologically savvy supportive conversations as evidence shows this leads to teams performing better and taking less sick leave.[5 9] Yet equally, many feel more comfortable sharing concerns with their peers; indeed, such concerns may relate to their managers. Peer-supporters, properly trained and supervised, can help maintain staff resilience; one example, is the 'TRiM' Trauma Risk Management) programme developed by the UK military and now used within the NHS.[10] While not 'penicillin for trauma', it is evidenced to support traumatised staff, reduce sickness and facilitate access to professional care. Leaders should thus ensure that structured peer support is available for staff while noting that organisational mental health screening programmes are not effective.[11] There are many reasons for this, including concerns about being labelled as weak, having a negative impact on one's career and perceiving support as a tick-box exercise.

However, despite well-constructed primary and secondary prevention strategies, some staff will need professional assessment and care. The current crisis is likely to cause an increase in anxiety and depressive disorders; some also may develop PTSD. Leaders should ensure there is rapid access to 'frontline' mental health professionals (MHPs), who focus on helping staff to return to duty and thus conserve staffing levels. These MHPs should use the four PIES principles (proximity, immediacy, expectancy and simplicity), which 'de-medicalise' normal (even uncomfortable) responses and reinforce practical measures that can often be implemented by supervisors. Most staff experiencing early trauma symptoms will find that managed proactively, these settle-down spontaneously, and the use of PIES has been shown protect staff's mental health in the longer term.[12] However, NICE recommends active monitoring of trauma-exposed staff and a minority will undoubtedly need formal, rather than PIES, treatment.[13] The earlier such treatment commences, the greater the likelihood that long term disability will be avoided.

We strongly encourage healthcare leaders to follow the preventive medicine evidence; ensure your staff are properly prepared for their role practically and psychologically, provide basic equipment and training, empower teams to support each other—with a particular focus on helping supervisors feeling confident to speak to team members about their mental health—and adopt a 'nip it in the bud' approach; have MHPs in a supportive and supervisory role with them providing early 'return to duty' focused care for those who need it; and lastly, ensure that

all trauma-exposed staff are actively monitored as the country begins its return to the new normal. An effective staff mental health plan fulfils legal requirements under duty of care and maximises the numbers of functional staff available to carry out life saving care while protecting the organisation's quality of care, staff morale and reputation.

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