

# The psychological impact of the coronavirus pandemic on healthcare staff

Neil Greenberg and Derek Tracy  
King's College London

# Risks to mental health during COVID 19

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**Traumatic exposure**

**Workload and shift patterns**

**Home life stressors**

**Moral injury**

# Definitions of Moral Injury



**Current definitions stress the potentially morally injurious event (MI):**

**Litz (2009):**

*“A psychological state that arises from events which involve perpetuating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations”*

**Shay (2014):**

*“The psychological consequence of a betrayal of what’s right by someone who holds legitimate authority in a high-stakes situation”*

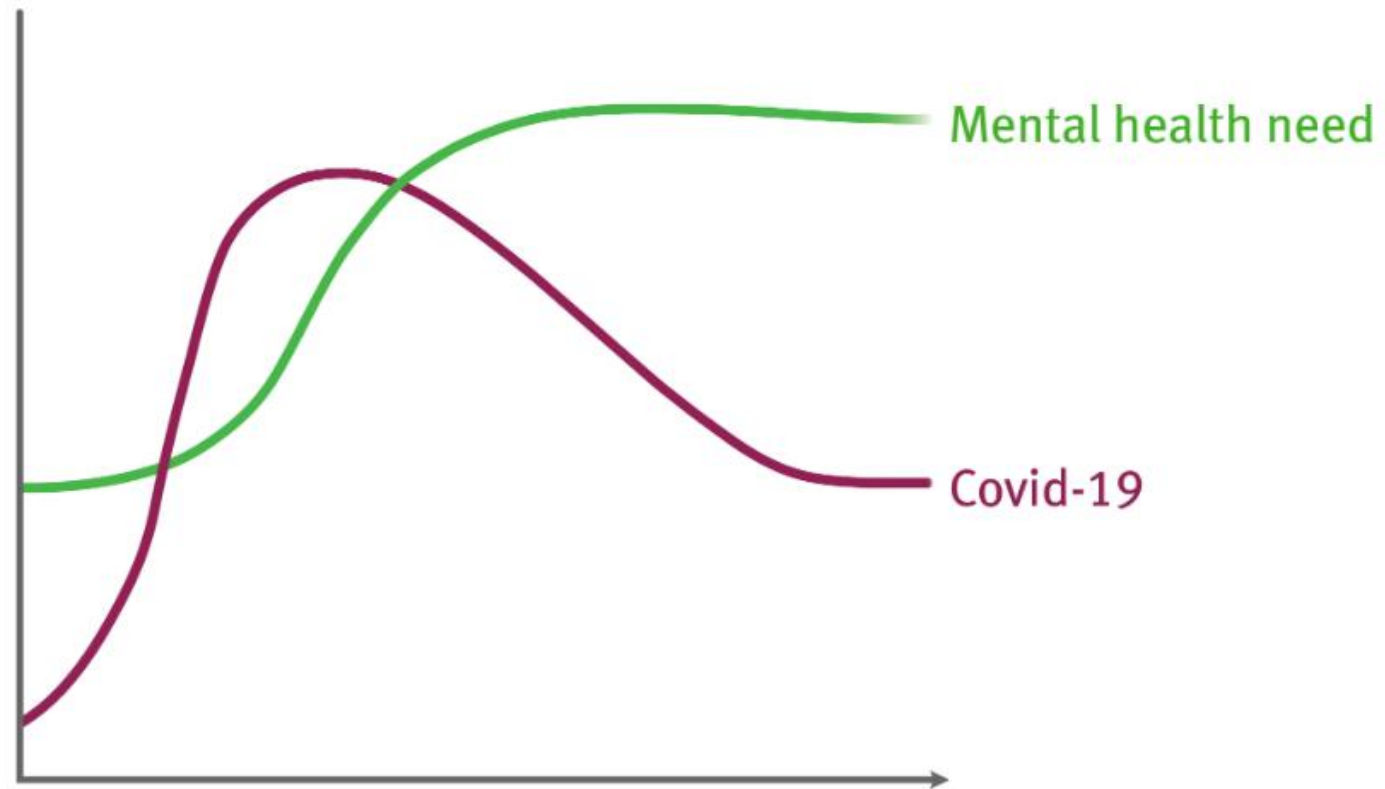
**Farnsworth (2017)**

*“A situation occurring in a high-stakes environment where an individual perceives that an important moral value has been violated by the actions of self or others”*

**Acts of commission, omission or betrayal by a higher authority**

# CMH report – May 2020

Projection of mental health need relating to Covid-19 and how it compares with the trajectory of the virus itself



# Who is at risk – general population?

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**Economic impact similar to post 2008 recession: 500K more people experiencing MH problems esp depression**

**Some communities, e.g BAME & poverty**

**Complicated grief**

**20% of ICU survivors known to get PTSD; plus post COVID sx**

**Occupational groups - inc HCW and other key workers**

**Those who previously had, or were at risk of having, MH problems**

# Long term effects post pandemics in healthcare workers

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## **Healthcare workers in 9 Toronto hospitals (Maunder et al., 2006)**

Burnout (30% vs 19% in comparison)

Psychological Distress (45% vs 30% in comparison)

Posttraumatic stress (14% vs 8% in comparison)

perceived adequacy of training, moral support, and protection were associated with better outcome

## **SARS Survivors in Hong Kong (Lee et al., 2007)**

One year after the outbreak, health care worker SARS survivors were also substantially more distressed on all dimensions of psychological distress (depression, anxiety, perceived stress, and posttraumatic stress) than their non–health care worker counterparts

Depressive symptoms - 36.3% (moderate-to-severe) and 4.4% (extremely severe) of participants.

Anxiety symptoms – 36.7% (moderate-to-severe) and 14.4% (extremely severe) of participants

**Allan et al. 2020 (PP) 12 month PTSD was 11.9% HCW**

**Harvey et al. 2020 (PP) PTSD 11.7% post COVID-19 HCW**

# Risk factors in HCWs

- Systematic review of 59 studies (Kisely et al., 2020)
- High exposure to virus-related work staff were 1.7 times more likely to develop symptoms of post-traumatic stress and psychological distress

- Risk factors
  - Younger and being more junior,
  - Parents of dependent children
  - Longer quarantine
  - Lack of practical support,
  - Stigma

- Protective factors
  - Clear communication,
  - Perceived adequate PPE
  - Adequate rest
  - Practical and psychological support



# Personal Protective Equipment

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“Many staff mentioned that they did not need a psychologist, but needed more rest without interruption and enough protective supplies” **(Chen et al., 2020)**

## **Impact of inadequate safety material in the armed forces (Simms et al., 2020)**

3435 military personnel deployed in operational environments

Associated with higher odds of reporting symptoms of:

- Poor general health (OR 2.09)
- Emotional problems (OR 1.69)
- Common mental disorders (OR 2.49)
- Probable PTSD (OR 2.99)

## **The impact of having inadequate safety equipment on mental health**

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# So what to do?

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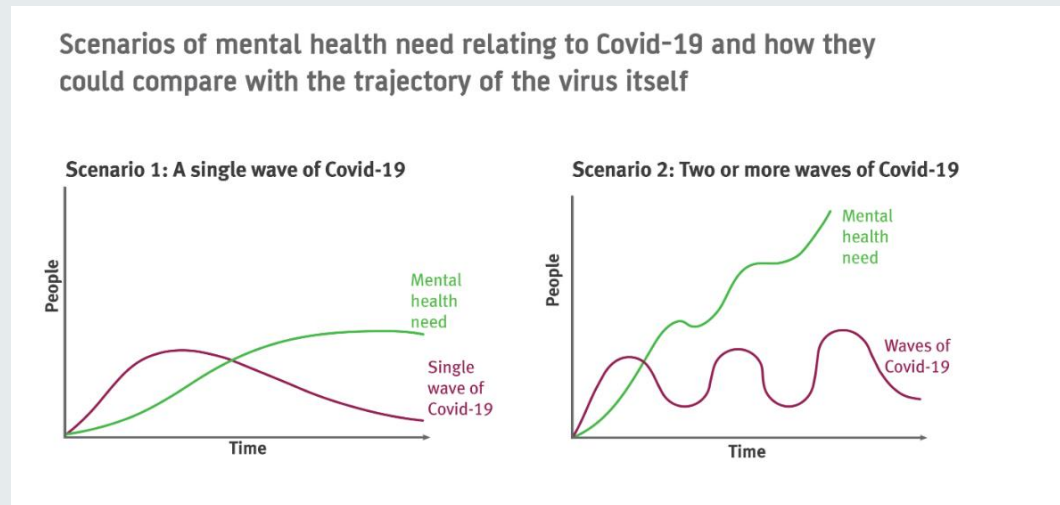
# General population

**Financial safety by the government**

**Employers, schools and public bodies should ensure proper support and trauma informed practice/care**

**NHS should offer proactive and tailored MH support to higher risk groups**

**NHS needs to prepare for longer term support offerings especially if there are multiple outbreaks**



# Prepare

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**Self check before taking up the role**

**Frank preparatory briefings**

**'Psychological PPE'**

**Role specific training**

# Psychological 'Pre-' Screening

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**Seductive**

**Psychometric, personality, 'lie detecting'/validity scales..... (e.g. MMPI)**

**Grandmother test is good**



# King's Centre for Military Health Research ([www.kcmhr.org](http://www.kcmhr.org))

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# Screening does not work in police recruits – 7 year follow up

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*Occupational Medicine* 2020;**70**:162–168

Advance Access publication on 10 February 2020 doi:10.1093/occmed/kqaa008

## A prospective study of pre-employment psychological testing amongst police recruits

**R. E. Marshall<sup>1</sup>, J. S. Milligan-Saville<sup>1,2</sup>, Z. Steel<sup>1,2,3</sup>, R. A. Bryant<sup>2,4,✉</sup>, P. B. Mitchell<sup>1,2</sup> and S. B. Harvey<sup>2</sup>**

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# Buddying up

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**One professional group did not engage well with this: which one?**



# Post-shift 'psychologically savvy' conversations & post-shift reviews

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**Have you the time? Will people engage? Watch for 'presenteeism'**

# Forward mental health supervision and support (PIES)

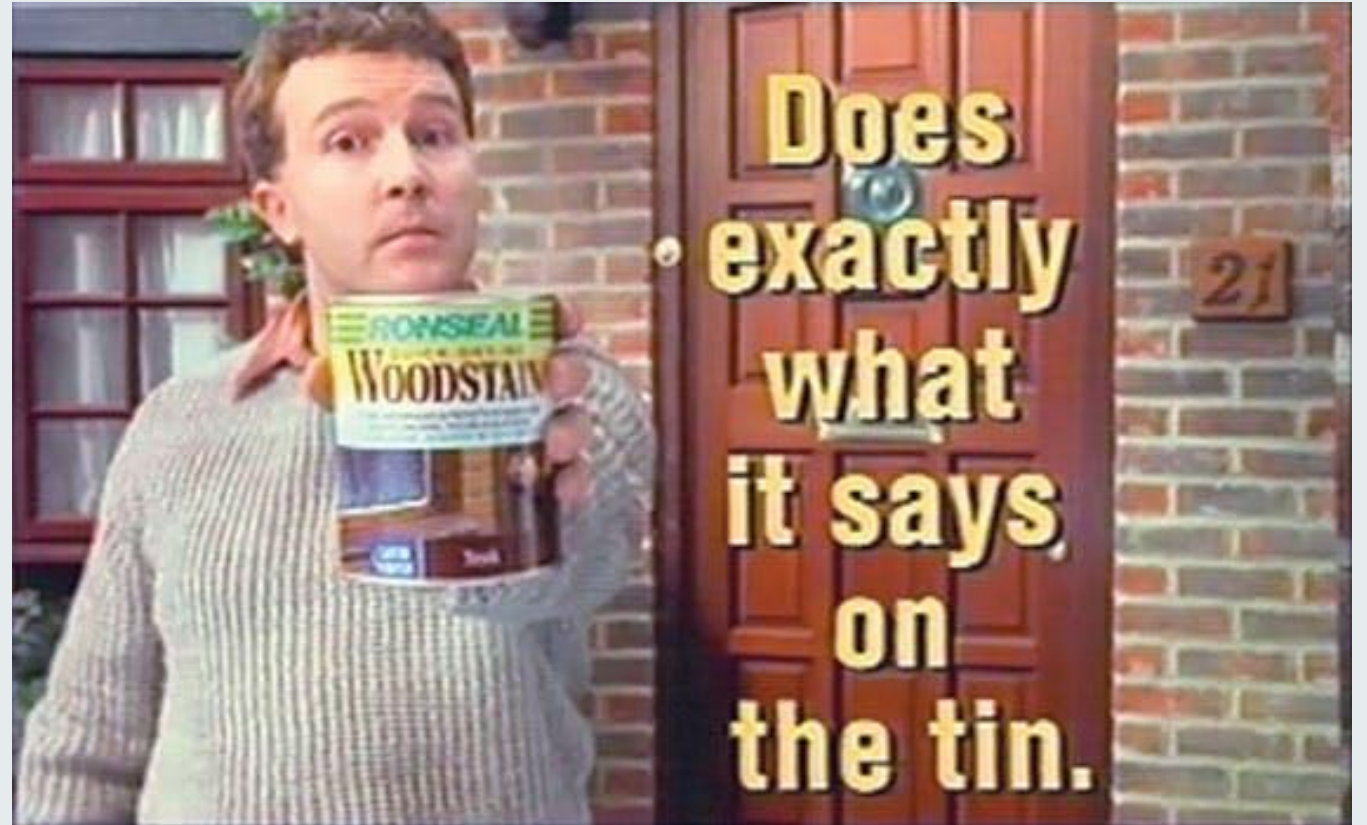
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**P**roximity

**I**mmediacy

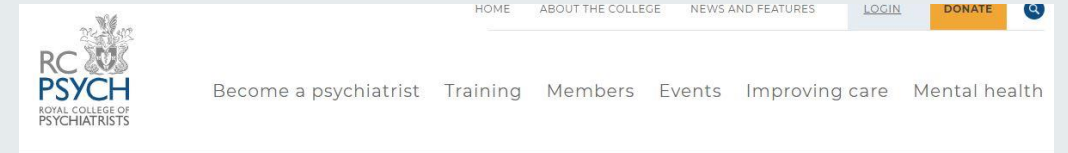
**E**xpectancy

**S**implicity



Post-traumatic *growth* is to be expected in most

# Thank you and provision of information



[Home](#) > [About the College](#) > [Responding to COVID-19](#) > [Guidance for clinicians](#)

## COVID-19: Guidance for clinicians

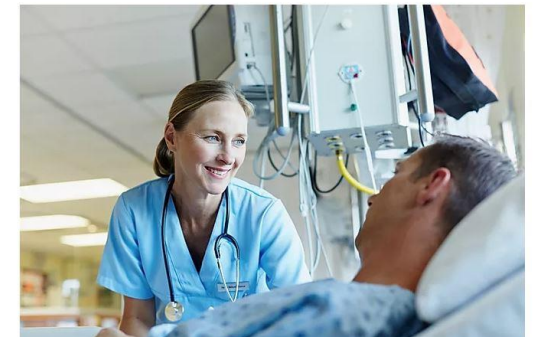
As the NHS response to Coronavirus (COVID-19) moves quickly, the College is working with NHS England and Improvement (NHSE/I) to update guidance for psychiatrists and other healthcare professionals working in mental health settings.

The full extent of the impact of COVID-19 is impossible to accurately predict and the situation is anticipated to rapidly evolve. We will continue to update and add to these pages over the coming weeks. You can also refer to the [evidence-based guidance](#) on COVID-19 and clinical management of mental health issues developed by The Oxford Precision Psychiatry Lab (OxPPL).

traumagroup.org

## COVID TRAUMA RESPONSE WORKING GROUP

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# **Graded return to work & ongoing psychological health screening**

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**Some aspects are nationally driven: quarantining, shielding etc**

**Some aspects are locally driven: do you know your Trust policy & team implementation?**

**How do you stratify risk where you are? What do you do for BAME staff?**

## Risk Assessment form for individual staff members particularly those in any higher risk group or disproportionately affected by COVID-19

It is the joint responsibility of line managers and staff to complete a risk assessment for staff, particularly those at higher risk of COVID-19 infection or possibly disproportionately affected by COVID-19, as set out by [Public Health England](#) (PHE) and [NHS England](#). As not all underlying health conditions are routinely declared, staff are encouraged to speak to their managers if they feel they need a risk assessment linked to a previously undeclared issue to enable appropriate support to be provided.

The aim of this assessment is to understand the specific risks staff members face who are more vulnerable to exposure to COVID-19 and enable these risks to be mitigated as far as possible. It should be completed in conjunction with the latest guidance from Public Health England.

Individual		
	✓	Individual Risk Level
High (very high)		Extremely vulnerable
High health		
Health		Clinically vulnerable
Diabetes, Chronic heart disease, Chronic respiratory disease, Immunosuppressed by disease or treatment, Obesity		
Pregnant: under 28 weeks gestation		Other factors
Black, Asian and minority ethnic staff (BAME)*		
Pre-existing mental health condition		
Other specific concerns e.g. disability		
Concerns related to home environment – e.g. living with someone who is shielding, difficulties with caring responsibilities etc.		
Individual Assessment Notes (e.g. details of conditions or home environment concerns)		

In the absence of any current formal PHE guidance we are identifying possible increased rates of COVID-19 infection amongst BAME communities in particular Black and Asian (African, Caribbean, Pakistani, Bangladeshi, Filipino, Chinese, Japanese).

2. Assessment of Environment		
Current post involves:	✓	Environment Risk level
Directly caring for COVID-19 patients (tested as positive) and undertakes Aerosol generating procedures (AGPs)		High Risk Environment
Directly caring for COVID-19 patients (tested as positive) – not undertaking AGPs		Moderate Risk Environment
Directly caring for patients not tested / unknown COVID-19 status but within 2 metres of patient – within any setting		

Directly caring for patients not tested/unknown C-19 status but more than 2 metres of patient – within any setting		Low Risk Environment
Providing a service in a care setting but not directly caring for patients (e.g. cleaning, estates, IT) but may have contact with patients not tested/unknown C-19 status		
Providing a service but not directly in the care setting (e.g. training, admin)		

3a. Risk assessment & mitigation for extremely vulnerable or > 28 weeks pregnancy or underlying conditions in any gestation		
		✓
Extremely vulnerable	Shielding. Should work from home where possible, but not on-site.	
Pregnant after 28 weeks gestation or with an underlying health condition in any gestation	A more precautionary approach is advised. Women in this category should be recommended to stay at home. For many healthcare workers, this may present opportunities to work flexibly from home in a different capacity, for example by undertaking telephone or videoconference consultations, or taking on administrative duties.	

3b. Risk assessment for all other groups			
Environment Assessment	Individual Assessment	Risk Level	
		Not clinically vulnerable	Clinically vulnerable/pregnant
		✓	✓
High risk environment		Lower Risk (2)	Higher Risk (1)
Moderate risk environment		Lower Risk (2)	Lower Risk (2)
Low risk environment		Very Low Risk (3)	Lower Risk (2)

# **Timely access to evidence based care**

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**Evidence base for mental illnesses is fairly clear (even if outcomes vary)**

***Access can vary in clarity and ease***

**What is your local process: via line management (what if your manager is the problem), primary care, occupational health, external agencies?**

**Substance use services?**

**Are you aware of the 'national offers' re covid-19?**

# **Supervisor discussions esp for higher risk/secondary stressors**

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**If you are a manager or leader, how well do you know your staff?**

**How well do you know their backgrounds and risk factors?**

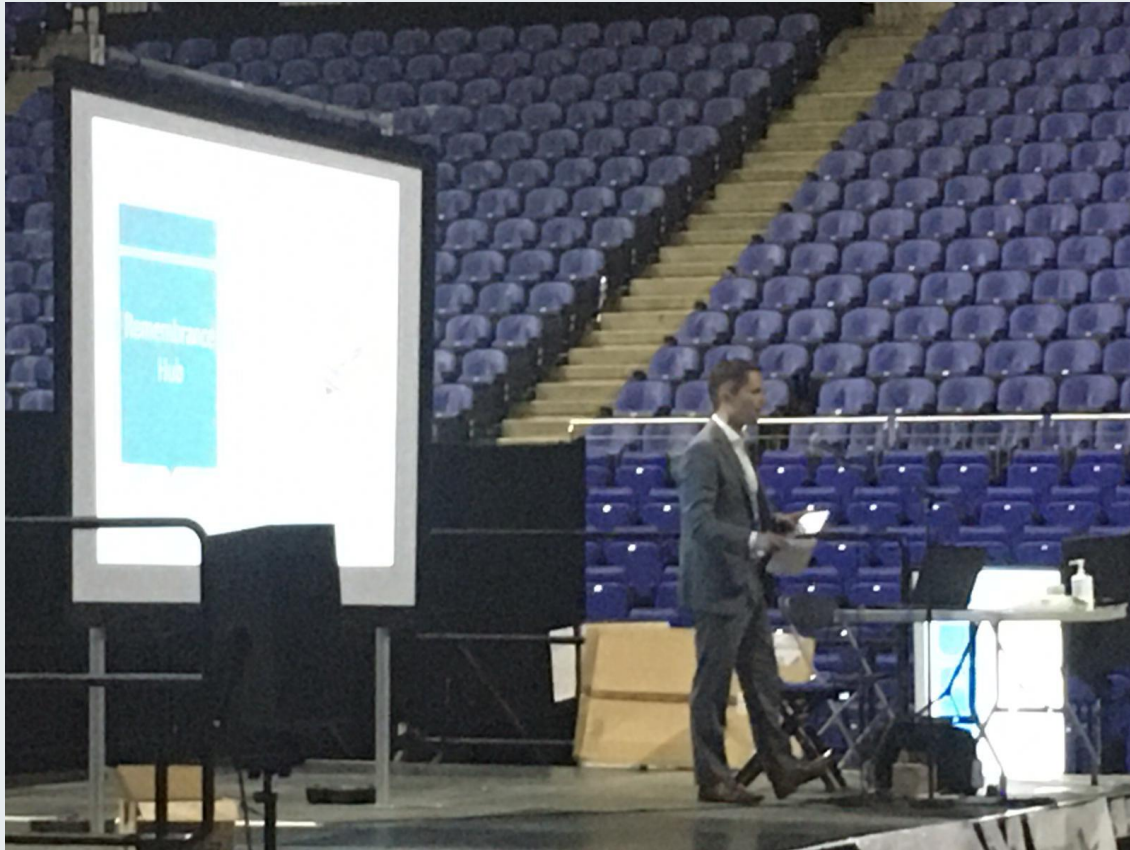
**Remember the resilience resources we are all *lacking* at this time**

**What is your plan for supporting them?**

**If it is 'not your role', whose is it?**

# Time for reflection/meaning making

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***Schwartz rounds* are one potential model to discuss emotional & social aspects**



# Conclusions of what to do

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**Do not over medicalise**

**Nip it in the bud approach**

**Build team support as a priority**

**Psychologically savvy supervisors**

**'Forward mental health teams'**

**Thank you, phased return to work and time for reflection**

**Active monitoring and evidence based care**

# Taking this to PICUs; questions to you

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**The Nightingale is clearly unique: a clean slate with enormous resources  
Yet, it was the application of an evidence base to a 'local problem'**

**How do you take this forward; what is common, what is unique?**

**Are there longer-term opportunities from the Covid-19 crisis to do things better?**

**Covid-19 is one (extreme) example of the pressures we will always face**

*Editorial*

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**COVID-19 and prisons: Providing mental health care for people in prison, minimising moral injury and psychological distress in mental health staff**

*Medicine, Science and the Law*

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# Any Questions?- Fire Away!

Thanks to all the Nightingale London  
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