

# **A STATEMENT FROM THE ROYAL COLLEGE OF PSYCHIATRISTS ON THE ROLES AND WORK OF PSYCHIATRISTS DURING THE COVID-19 PANDEMIC**

## **Introduction**

Healthcare staff working in the current pandemic are likely to face a range of stressors including workplace stress, home pressures, traumatic exposure, moral distress and the risks of moral injury. The currently unprecedented circumstances also come at a time when NHS staff are already stretched, services are often understaffed and when organisational morale may be far from ideal.

This document identifies the important role that psychiatrists continue to have during the COVID-19 pandemic in delivering care for their patients and it describes a preventative model of occupational mental health for psychiatrists who are invited to assist their colleagues in general hospitals and the temporary COVID-19 hospitals.

## **Sustaining Mental Health Services**

The introductory description applies to mental health services just as much as it does to all healthcare services. The Royal College of Psychiatrists is highly conscious of the persistent pressures that have been prevalent in mental health services across the UK from well before the advent of COVID-19. Superimposed on this, COVID-19 presents huge challenges to clinical staff and managers of all specialties including mental health and primary care services to maintain community- and hospital-based mental health services. There are problems in delivering services that stem from social distancing and isolation policies, but patients with mental health problems are no less at risk of contracting COVID-19.

In this circumstance, the Royal College of Psychiatrists sees the primary role of psychiatrists as remaining that of providing as high-quality care as possible for patients who have mental health disorders. This calls on them to continue to be excellent, and also as flexible as they can be, in the present very demanding circumstances. For example, the staff of mental healthcare services should be trained to use personal protective equipment (PPE) and practised in safely donning and removing it safely.

Briefly summarised, this means that all psychiatrists should remember that they have much-needed expert skills to support their existing, and new patients, who are likely to need them more than ever now.

## **Psychiatric Support for Frontline Healthcare Professionals**

Understandably many mental health professionals, including psychiatrists of all grades, have a considerable desire to assist their clinical colleagues in order to protect their mental health and in doing so contribute to the national effort to save lives. In certain instances, psychiatrists may be well-placed to offer professional advice and/or support for colleagues who are

working in physical healthcare services, when asked to do so. This document provides outline guidance on this topic in order to assist psychiatrists to act in a way that is helpful and, as importantly, to avoid doing harm.

If asked, staff of healthcare organisations should be advised to adopt a ‘nip it in the bud’ approach (see below) and to foster and maintain effective social connections between team members and their team leaders and/or supervisors. Psychiatrists should be ready to provide expert advice, early assessment and, when necessary, treatment for staff members, with a view to their returning to work, and for patients about whom the clinicians responsible for their care are concerned that they may be developing mental disorders. The College is keen to negotiate with the administrations in all four countries in the UK a mechanism to deliver these services. The opinion of the College Officers is that an equitable response to these requests requires a national framework for specification, commissioning and delivery of the services required.

Psychiatrists without relevant experience or training in occupational mental health, or similar, should ensure that they acquire and develop the right knowledge and skills before providing advice, support or care that may be beyond their current expertise. Accessing supervision from colleagues with the right skills and experience is likely to be helpful.

A core axiom is to recognise that acute hospitals already have good team structures and their own support and leadership systems in place, and they should not be disrupted. This document describes a range of possible interventions that take this into account and it follows a preventative model of occupational mental health. As a reminder, primary prevention refers to interventions that aim to avert the onset of mental health disorders; secondary prevention to interventions that focus on people who have early signs of possible mental health disorder; and tertiary prevention to treating people who have developed mental health disorders.

## **Primary Prevention Measures**

### *Preparatory briefings*

Psychiatrists should be aware that frontline, trauma-exposed<sup>1</sup>, staff are likely to gain some benefit from being made aware of the realities of the work they are being asked to do and the associated psychosocial challenges. This requires organisations to be upfront about what the likely occupational exposures might be and not to either over- or under-state the traumatic nature of a particular role.

In the current crisis, preparatory briefings should include discussion of the moral and ethical challenges of the current situation as well as the likely workplace pressures and traumatic exposures as well as fears of becoming infected and, by implication, infecting others.

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<sup>1</sup> Traumatic situations are ones involving death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence once or on multiple occasions. In their course of their duties, staff may be exposed to traumatic situations directly, as a witness or through indirect exposure to aversive details of the trauma in the course of their professional duties.

Psychiatrists may have a role in helping clinical team leaders, who should be delivering these briefings, to understand the psychosocial risks their teams face and help them understand the concepts of moral distress and moral injury. It is unlikely to be appropriate for psychiatrists to deliver these briefings because they are best done by leaders within the clinical teams that are providing care.

#### *Pre-recruitment screening*

Psychiatrists should be aware that there is no role for formal pre-recruitment screening in predicting psychosocial vulnerability in trauma-prone roles. Should psychiatrists be asked about how best to select frontline healthcare staff based on screening for psychosocial vulnerability, their answer should be that such an approach has no merit. However, appropriate consideration of someone's fitness for role by occupational health colleagues should be advised and, if occupational health services have concerns about someone's history of psychological health, then discussion with a psychiatrist, who has an interest in occupational mental health, may be of benefit.

#### *Social support*

There is very good evidence that fostering cohesion between staff, both horizontally [camaraderie] and vertically [leadership], is consistently associated with good mental health. Furthermore, social connectedness and social support have been shown to be two of the most potent influences on people's health and longevity. Essentially, most of the resilience of an organisation may lie in the social bonds between staff members rather than within individual people. Psychiatrists may be able to help encourage team leaders/supervisors to recognise this and make active efforts to improve the quality of the social connections between team members. It may also be helpful to advise frontline teams to adopt a buddy-buddy approach in which team members are paired in order to check on each other's welfare during shifts as this can be an effective way of actively monitoring staff to identify early signs of distress. The approach built on staff Huddles used in some ICUs has similar intentions.

#### *Supervisory leadership*

There is very strong evidence that psychosocially savvy supervisors play a critical role in supporting the mental health of team members. Studies have shown that teams operating in even the most arduous of environments are more likely to function well, and avoid the onset of serious mental health difficulties, if their supervisors create the right team ethos. Good leaders and supervisors have a range of important skills and attributes including: looking out for team members' safety; communicating with team members regularly; not taking on excessive amounts of extra work because of their dedication or to make themselves look good at the expense of their team members; and not criticising team members in front of others. Psychiatrists may be able help inform, or upskill, team supervisors on topics such as active listening skills, and basic understanding of the likely impacts of exposure to significant moral/ethical dilemmas and psychological trauma. They can also help supervisors to develop

the confidence to have a supportive conversation with staff about their mental health including what to do if they identify a problem.

### *Team training*

As well as developing each team member and the skills of teams (e.g. in resuscitation, infection control etc.), training groups of staff together presents an important opportunity for fostering strong links between team members and helping staff to develop a sense of being in control over, otherwise unpredictable and anxiety provoking, situations. Psychiatrists should encourage leaders/supervisors to see team training events as opportunities to improve the mental resilience of their teams and foster camaraderie.

## **Secondary prevention measures**

### *Active monitoring*

The National Institute for Health and Care Excellence's (NICE) guidance on managing people who have PTSD, published in 2018, recommends active monitoring of people who have been exposed to traumatic events in order to identify whether any early symptoms resolve [which is to be expected in most cases]. If early symptoms do not resolve, individual persons should be assisted to access sources of professional assessment and support. While NICE recommends active monitoring to identify symptoms of PTSD, it is also a useful approach for people who may have any form of post-trauma mental ill-health such as depression, phobias or other anxiety disorders.

Active monitoring should be a function of teams [i.e. by team leaders, supervisors and colleagues]. Psychiatrists may have a role in providing advice to leaders about staff whose needs are unclear or complicated. Examples include someone who becomes distressed as a result of one or more traumatic exposures and appears to be recovering, but then deteriorates, or someone who appeared to be unaffected by the ongoing trauma but then starts acting out of character. In this way, psychiatrists with the right experience (e.g. occupational mental health, liaison etc.) can act as trusted expert resources for supervisors and team leaders by assisting them to manage their staff more effectively.

### *Psychological debriefing*

Psychiatrists should be aware that psychological debriefing, or post-incident counselling, has been shown to be more detrimental to the psychological wellbeing of traumatised people than their not being provided with any psychologically-focused intervention at all. NICE specifically recommends against the use of psychological debriefing. Psychiatrists should advise against using these approaches and should not provide them themselves. However, it is important to distinguish psychological debriefing from leader-led operational debriefing [i.e. identifying the reasons for specific outcomes and identifying ways of improving practice], which is likely to be a facet of good leadership and should, thus, be encouraged

## *Screening*

Screening people's psychosocial health after incidents aims to identify people who have developed early signs of, or have established, mental health problems in order to help them to access professional care. While this is well intentioned, there is no evidence that this approach works in organisational settings. It is likely that concerns about: what employers will do with screening results; reputation; confidentiality; and screening only being a 'snapshot' in time, which does not take account of the usual fluctuating course of mental health disorders, are some of the varied reasons why screening within organisational settings is not effective. Post-incident screening, may also do harm by falsely reassuring employers that staff members are psychosocially healthy when this is not true. If asked to support post-incident screening initiatives, or ongoing psychosocial health monitoring, psychiatrists should advise those making requests that screening is not an effective tool in workplace settings.

## *Peer support programmes*

There are a number of protocols for training peers to actively monitor and support colleagues within workplaces. One of the essences of peer support is that it is provided by staff who are engaged in the same or similar activities within the service and another is that the programme should be actively supported by employers. Huddles are presently being used by a number of teams in acute services at the close of shifts, for example. Psychological First Aid, Mental Health First Aid and Trauma Risk Management (TRiM) are other modalities of peer support that may be available, if services have these activities in operation already.

These programmes may have some utility in encouraging staff who are reticent to speak to their managers, or use more formal processes for supporting the mental health of staff such as an Employee Assistance Programme (EAP), to speak about their difficulties. Leaders and managers may also use peer supporters to carry out active monitoring of trauma-exposed staff as discussed above.

Psychiatrists may have a role in supervising and supporting peer supporters in order to: ensure that they do not become vicariously traumatised when carrying out their work; help them to implement practical measures with staff members they are supporting; and be available to discuss difficult cases with them in a supervisory relationship. Psychiatrists who wish to support a peer support network should ensure that they liaise with the team leader for peer support so as to avoid giving conflicting advice and ensure that they are fully aware of the peer support operating procedures including the limitations of peer supporters' role.

## *Overcoming barriers to seeking care*

As psychiatrists will be well aware, there is considerable evidence that stigma relating to mental health, perceived fears about reputation and the impact on careers, of developing mental health difficulties can act as barriers to care. A reluctance to seek help may be particularly evident in staff who work routinely in high-risk roles; staff in these circumstances

may believe there is a need to be mentally and emotionally strong in order to maintain their reputations and, indeed, their employment. Psychiatrists may be able to help more senior managers within healthcare settings to remain cognisant of these problems and help by advising on campaigns to encourage appropriate help-seeking.

Psychiatrists can also advise managers that symptoms and functioning are not always directly linked and many people who have mild, or even moderate, psychological symptoms may remain highly functional. During the COVID-19 crisis, there is the need to keep as many healthcare staff at work as possible; this is more likely if organisations can adopt a 'nip it in the bud' approach which requires people to be willing to approach sources of potential support (e.g. colleagues, supervisors, peer supporters, team leaders, chaplains) early on. If psychiatrists can help senior managers to implement appropriate strategies to encourage early help-seeking, this is likely to foster a 'nip it in the bud' approach across the organisation.

### *Early triage assessments*

Many Armed Forces use mental health professionals, deployed alongside or near to, operational troops to carry out mental health assessments of their fitness for duty. These professionals aim to rapidly assess whether someone who presents with significant distress can be assisted to return to the frontline, possibly with brief advice and/or workplace adjustments that are likely to temporarily lessen their exposure to stress [e.g. moving into an administrative role for a while], or whether they require more formal mental healthcare.

Psychiatrists who have an interest/experience in occupational mental health are able to offer rapid assessment of frontline healthcare professionals who cannot be readily managed within their usual team even when a manager has tried to do so. The focus of these assessments should always be to try to find appropriate avenues to return people to functional roles, even if it is to support the main effort rather than being directly in the frontline.

It is important that psychiatrists who carry out these brief assessments keep in mind that there is a pressing need to have sufficient healthcare staff on the frontline in order for lives to be saved. Often simple support measures such as advising distressed staff to get a good night's sleep, communicate with a loved one, take some exercise or have a shower can have a substantial impact on their mental health and ability to continue functioning. At times, psychiatrists may also be able to reassure staff who have mild symptoms that they are anticipated and to be expected and not indicative of serious mental health problems. If frontline staff have profound mental health problems that are likely to significantly impact their ability to carry out their roles safely, these risks should be actively managed and care should be arranged rapidly. Should someone require a period of respite or care, psychiatrists should aim for that to be as brief as possible.

The principles of returning people who are distressed to duty are described by the acronym PIES. There is good evidence that not only does enacting these principles help people to continue to work, but they also have a longer-term positive impact on people's mental health,

possibly by helping them to maintain their self-esteem and avoid them labelling themselves as someone who cannot handle pressure. The PIES principles are:

- Proximity: This refers to keeping people who are finding the situation tough near the frontline [possibly, by altering their duties for a brief period] and not simply sending them home;
- Immediacy: If someone does not seem to be themselves, do not wait for them to enter a crisis before finding out how they are doing and supporting them;
- Expectancy: This refers to keeping a positive outlook in mind be that reassurance that they will cope and are doing a great job, or that, if they really cannot cope, then they will be properly looked after;
- Simplicity: This refers to the benefits of simple interventions in helping to alleviate distress such as those described above [e.g. speaking to a love one, a good night's sleep etc.].

Psychiatrists should also actively liaise with occupational health colleagues about options relating to fitness for duty when doing so is likely to be helpful.

## **Tertiary prevention**

### *Treatment*

The NICE guidelines, published in 2018, on managing people who have PTSD recommend that adults should be offered a trauma-focused CBT intervention if they have acute stress disorder or clinically important symptoms of PTSD, and have been exposed to one or more traumatic events within the last month. These interventions include: cognitive processing therapy; cognitive therapy for PTSD; narrative exposure therapy; and prolonged exposure therapy. Psychiatrists who identify healthcare staff who have acute stress disorder or clinically important symptoms of PTSD, should arrange for these evidence-based interventions to be delivered and should also consult the NICE guidelines for managing PTSD for other useful information. NICE guidelines for treating people who have other mental health conditions (e.g. depression) should also be adhered to.

### *Rehabilitation and Returning to Work*

Alongside providing evidence-based care, psychiatrists should help their patients to find ways to return to duty. Being able to return to duty is not just useful for helping to save lives, but is likely to have a role in maintaining healthcare worker's self-esteem and protecting their longer-term mental health. Psychiatrists should be aware of vocational rehabilitation approaches, such as IPS [individual placement and support], which follow the principle that people should be supported to return to appropriate work as soon as they reasonably can. Care teams should not wait until they consider someone is fully 'work-ready' before recommencing appropriate work. Once again, liaison with occupational health colleagues may also be helpful when considering return to duty.

## **Conclusions**

All psychiatrists should remember that they have much-needed expert skills to support existing and new patients who need them more than ever just now.

During the current COVID-19 pandemic, there are likely to be numerous ways in which psychiatrists can help their general hospital colleagues to sustain their psychosocial resilience and that of their teams in the face of considerable adversity. This document sets out some of the evidence-based approaches that psychiatrists can utilise.

Psychiatrists without relevant experience or training in occupational mental health, or similar, should ensure that they acquire and develop the right knowledge and skills before providing advice, support or care that may be beyond their current expertise or, at the very least, seek support and supervision from someone who has relevant experience.

In summary, helping healthcare organisations to: adopt a 'nip it in the bud' approach; foster and maintain effective social connectedness between team members and their team leaders and supervisors; and providing expert advice, early assessment and, when necessary, treatment are all likely to be useful interventions to which psychiatrists can contribute during the current crisis and beyond.