Phases of COVID-19 crisis and expected needs, recommendations and possible role of psychology

##### Robin Paijmans and Dr Helen Guy, consultant clinical psychologists (2020)

This model is based on Leach (1994), Tehrani (2004, 2010), Math et al. (2006), BPS (2018), Highfield (2020). It allows us to anticipate psychological needs and impact on wellbeing, and focus and co-ordinate interventions on a flexible, dynamic basis.

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| Phases: | Issues | Needs and recommendations | Role of psychology service |
| Anticipation phase | Anticipatory anxietyFeeling overwhelmed, unable to planCommunication errorsTeam tension“Readiness burnout” | ORGANISINGACKNOWLEDGINGEXPRESSING Clear communication.Escalation plan.Support managers who are making plans and holding the stresses. Increase resilience resourcesTeam containment, reassurance and planning. | PROMOTIVEPsychological and Wellbeing guidanceLinking with mental health teamsLinking with senior managementScoping psychological support workforce  |
| Initial impact phase  | Heroic stageStriving – collapse cylclingStarting to get goinglots of trying out | ADAPTINGSTRESS MANAGEMENTPSYCHOLOGICAL FIRST AIDACCOMMODATINGLOSSES AND SETBACKSManagement are visible and available. Regular communication bulletins and open forums. Promote peer support. It’s okay to say you are not okay - Senior staff to model this. Rotate workers from high-stress to lower-stress functions. Small pre-brief and debrief every day. Partner inexperienced workers with experienced (also military?) colleagues. Drop in sessions for staff with employee wellbeing.Ensure the basics: Breaks, Facilities (food trolley in staff room), videogames, entertainment; Sleep, days off. Manage visitors. | PREVENTIVEStress management for staff and leadershipDisseminate resources and information on normal psychological reactions to crises/trauma and psychological self-care.Identification of psychological support staff.Establish centrally co-ordinated telephonic psychology consultation service for staff dealing with psychological distress issues in patients and staff.Identification of sources of psychological support in the community.Briefing on key principles of psychological first aid for non-specialist psychological support staff.Input into Staff Health & Wellbeing Group. |
| “Honeymoon” stageLost time, repetition and frustration. Furtheranticipatory anxiety |
| Core phase | DisillusionmentstageBiggest risk period. Fear infection and implications for families.Overwhelming workload.Full go mode- adrenalin and automatic pilot. Exhaustion. Moral distress as healthcare rationing or deaths occur. Distress linked to personal or family experience/ bereavement of COVID-19. Experience fear or stigma when out in public. | SUSTAININGFacilitate sessions for staff to reflect on feelings and experiences in relation to e.g. treatment. decisions/dilemmas, deaths and other COVID-19 issues.Support of psychological support staff.Support of non-specialist psychological support workforce.Provision of information for staff to address staff exhaustion and burn-out and to promote psychological wellbeing. |
| End phase | Restorative stageExhaustion and post trauma recovery / stress | ACCESSINGAFFIRMINGRECONNECTINGSignal closure of core phase.Debriefing. Staff 1-1 and group sessions. Organise thanks and reward for everybody (no hero/martyr worship!). Learning and preparation for the future. Look out for signs of PTSD in staff: • on edge and hyper arousal, poor sleep • flashbacks or re-experiencing • avoidance of reminders | RESTORATIVEPreparednessInformation on PTSD and screening tools.Screening for PTSD in staff. Information on grief and loss.Consultation with managers around supporting staff. |
| Long Term | AftermathSome ongoing PTSD (20%?)Reflection and learning |

Stress… management for staff and leadership

##### Anticipation Phase:

At this stage anticipatory anxiety will be elevated as people feel unprepared and find it difficult to appraise the coming challenges, deal with uncertainty and respond to an evolving situation. Rumours may spread. Key is:

* Allowing people to express their concerns –to say that they are not OK
* Normalise concerns and worries and build resilience; promoting self-care
* Establish clear lines of effective communication

What clinical health psychology can offer:

* Scoping of psychological workforce in the hospital
* (With funding) recruitment of additional psychology staff
* Co-ordination with other sources of support for the staff support roles (e.g. Occupational Health)
* Co-ordination with local mental health services and patient support groups
* Identification of patients who are at psychological risk and implementation of risk management plans
* Advisory role to leadership team and clinical leads across the hospital

## Initial Impact Phase:

At this stage staff will rally as they are coping with the demands in front of them. There will be trial and error as staff adapt to different ways of working, bringing frustration and increased pressure. The risk is that staff will engage in “heroism”, overextend themselves in their roles and capabilities, not pace themselves and take unnecessary personal risks. In the “honeymoon” stage there may be a lot of attention by the media and politicians that may feed this behaviour.

* Continue to allow people to express their concerns –to say that they are not OK
* Promote peer support and self-care
* Daily small pre-brief and de-brief sessions
* Keep management visibly present and accessible
* Establish regular communication bulletins, open forums and drop-in sessions for staff with employee wellbeing services
* Rotate staff between high- to low-stress functions
* Partner inexperienced staff with more experienced colleagues
* Establish a supportive physical environment: Ensure the basics: Breaks, Facilities (food trolley in staff room), videogames, entertainment; places to sleep; planned days off.

What clinical health psychology can offer:

* Psychological first aid:
	+ Disseminate resources and information on normal psychological reactions to crises and potential trauma (**it’s OK to not be OK**), psychological self-care
	+ Identification of psychological support staff who can offer telephone support, counselling and triage to staff who are experiencing psychological distress as a result of COVID-19 to assist Occupational Health manage increased demand (with clear referral criteria)
	+ Establish centrally co-ordinated telephonic psychology consultation service (with admin support) for staff dealing with psychological distress issues in patients and staff related to COVID-19
	+ Identification of sources of support for psychological distress in the community
	+ Briefing around key principles for psychological first aid for the non-specialist psychological support workforce
* Input into Staff Health & Wellbeing Group

## Core Phase:

This tends to be the period of biggest risk, as staff act on “automatic pilot”, the situation may feel overwhelming exhaustion sets in and mistakes and burn-out are more likely. Moral distress will occur as healthcare rationing decisions have to be made and deaths occur. There will also be a fear infection and the implications of that for staff members’ families, and distress linked to personal or family experience/ bereavement of COVID-19. There may also be a fear or experience of stigma when out in public.

* The recommendations of the Initial Impact Phase are applicable here
* Ensure colleagues who may be experiencing dissonance between commitments to service vs. responsibilities at home (e.g. childcare, fear for vulnerable family etc.) have opportunity to discuss these concerns and optimally resolve them in collaboration with colleagues

What clinical health psychology can offer:

* Facilitate sessions for staff to reflect on their feelings and experiences in relation to e.g. treatment decisions/dilemmas, deaths and other COVID-19 and clinical issues.
* Support of psychological support staff who offer telephone support, counselling and triage to staff who are experiencing psychological distress as a result of COVID-19
* Support of non-specialist psychological support workforce
* Provision of information for staff to address staff exhaustion and burn-out, and to promote psychological wellbeing.

## End phase:

* Raise staff awareness of, and look out for out for signs of PTSD
	+ Information and screening tools
* Normalising grief and providing information about this
* Helping people to return to work / continue after the crisis period has waned

What clinical health psychology can offer:

* Information on PTSD and screening tools
* Screening for PTSD in staff –if additional psychological support staff recruited
* Information on grief and loss
* Consultation with managers around supporting staff

## General considerations:

* Phases are going to apply personally, not just professionally. Boundaries between the professional and personal may be strained, blurred or collapse
* Preparation must consider:
	+ Some staff may have significant issues and be more severely affected
	+ personal losses / staff deaths / relative deaths
	+ Ethical strain – making difficult decisions around treatments to be offered / not offered to patients / stopping treatments
* Continued supervision for those members of staff who are part of existing clinical supervision groups or arrangements