Annex 1 to the ICS Strategic Framework for Peer Support

Background Knowledge

Stress

Experience and research show that people are likely to respond in a wide variety of ways during and after their involvement, either directly or indirectly, in emergencies and major incidents. These reactions may vary but there are identifiable patterns and trajectories over time of their psychosocial response. This psychosocial response includes cognitive, social, emotional, behavioural and physical elements.

The trajectory of response shows that a significant proportion of people involved directly or indirectly in emergencies suffer distress in the two weeks to several years after single incidents. Repeated events or threats of related events and poorly managed responses may result in some people experiencing continued and sometimes, intensified, distress.

Everyone experiences stress. For some people, stress may result in them becoming distressed, that is, that their behaviours might be described as distressed or that their experience of stress is disconcerting and unduly unpleasant. Both primary and secondary stressors contribute to their distress.

In OP94, Principles for Responding to the Psychosocial and Mental Health Needs of People Affected by Disasters or Major Incidents, primary and secondary stressors are described as[1]:

Primary Stressors

Stress and anxiety for the people who are directly involved, and for their relatives, friends and colleagues and the practitioners and staff who intervene are inherent in all emergencies and disasters. The worries stem directly from the events. These sources of stress, worry and anxiety are called primary stressors.

Secondary Stressors

Secondary stressors are, by contrast, circumstances, events or policies that are indirectly related to the disastrous events or are not inherent in them. All too often, secondary stressors, such as failure of countries to deal effectively with people losing their homes, livelihoods or their financial stability, may persist after the events have subsided and their impact may be long term and devastating. Depending on the circumstances and the effectiveness of responses, their effects may be as great as or greater than the disaster itself or, as COVID -19 has indicated, the secondary stressors may be of greater impact than are the primary stressors.

[1] Williams, R., Bisson, J. & Kemp, V.OP94. Principles for Responding to the Psychosocial and Mental Health Needs of People Affected by Disasters or Major Incidents. The Royal College of Psychiatrists. London. 2014.

Caring for Healthcare Staff

This section focuses on caring for healthcare staff who have been affected by their involvement in emergencies and disasters and they may be susceptible to the psychosocial and mental health consequences of their involvement. A paper in BMJ Military Psychiatry describes the principles for delivering psychosocial care and mental healthcare.[2]

As the ongoing COVID-19 pandemic illustrates, the public has high expectations of healthcare staff. They expect that that services will be delivered in an environment that allows for compassion and sensitivity. They also expect that the services delivered will be based on the best research and evidence available. However, healthcare staff are likely to find it difficult to fulfil their ambitions for the delivery of safe, effective and compassionate care if the environment in which they have to work does not support a values-driven approach that includes appropriate training and assistance from their employers. This is most marked where there is a disconnect between what staff wish to provide and employers indicate, either explicitly or implicitly, that they wish staff to take more than minor risks.

Again, the pandemic has highlighted that staff may be in situations in which work is not generally benign or low risk but rather those in which the emotional and physical burdens of the work, such as working for long periods in full PPE, create psychosocial pressures on staff.

Healthcare is a particular form of work that involves working with people who are in crisis or who are ill. The work has much social value and meaning that can make healthcare staff feel positive about their value and when it is done well, it can create a feeling of having made a positive contribution to society as well as to the individual people being cared for. The obverse is also true when healthcare staff cannot fulfil what they feel to be their obligation to patients and families and they can be left with unvalued and unimportant.[3]

Generally, there is potential for healthcare practitioners to neglect their own physical and emotional needs. More extreme effects of the exposure of staff to crises and people's suffering include burn out, compassion fatigue, and vicarious or secondary traumatisation.

It should be the responsibility of healthcare organisations to ensure that their staff are provided with a work environment that ensures that they can work safely and effectively in a variety of circumstances. These circumstances may include one-off emergencies including terrorist attacks and human infectious diseases. Staff of healthcare organisations are no less susceptible to experiencing the distress that people directly involved in an emergency experience. However, they may feel that they cannot express their distress for fear of being stigmatised or because they think, altruistically, that other people should receive limited resources first.

Table 1 provides an overview of the psychosocial and mental health effects of disasters and the common kinds of disorders that people who are affected may develop. The effects may be similar for staff. Research suggests that staff who experience ongoing distress, that is, beyond two to four weeks after an event, or for who the nature of the distress intensifies, should have their needs assessed as they may require access to more specialist services in either primary or secondary healthcare services.

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[2] Williams R, Kemp V. Principles for designing and delivering psychosocial and mental healthcare. BMJ Military Health 2020.
[3] Williams R, Kemp V, Neal A. Compassionate care: leading and caring for staff of mental health services and the moral architecture of healthcare organisations. In: D Bhugra, S Bell, A Burns (eds). Management for Psychiatrists (4th edn). RCPsych Publications; 2016; 377-402.

Table 1: Indicators of distress adapted from Alexander D. 2005[4] reproduced with permission RCPsych

Emotional Experiences	**Cognitive Experiences**
Fear & anxiety	Impaired memory
Fear of recurrence	Impaired concentration
Helplessness &/or hopelessness	Confusion or disorientation
Guilt	Dissociation or denial
Anger	Intrusive thoughts
Shock and numbness[5]	Reduced confidence of self-esteem
Anhedonia	Hypervigilance
Social Experiences	**Physical experiences**
Regression	Insomnia
Withdrawal	Headaches
Irritability	Somatic complaints
Interpersonal conflict	Reduced appetite
Avoidance	Reduced energy
	Hyperarousal

There are predictors of factors that affect staff wellbeing and also their absence. They include the quality of relationships between leaders, managers and staff, the availability or otherwise of adequate resources to do the job, the state of communications about the quality of the emotional environment being worked in and whether there is appropriate support from managers and leaders as well as access to peer support. Other factors, such as the physical environment, are also likely to contribute to the ability of healthcare staff to maintain their wellbeing and emotional health.

Approaches to managing the pandemic have included redeploying staff to work in areas with which they are not familiar, for example, intensive care units. Lessons from deployment to international emergencies such as Ebola outbreak indicate that the manner of deployment and then the manner of support received when returning to their original workplace was important in ensuring the wellbeing of staff. As the report of the House of Commons Science and Technology Committee on 'Science in emergencies: UK lessons from Ebola' observes, "We can only admire the courageous and selfless actions of UK volunteers, and their West African counterparts, throughout the Ebola outbreak.[6]

[4] Alexander DA. Early mental health intervention after disasters. Advances in Psychiatric Treatment 2005;1:12-18.

[6] House of Commons Science and Technology Committee: Science in emergencies: UK lessons from Ebola. Second Report of Session 2015–16. HC 469. The Stationery Office Limited: London; January 2016.

The Moral Architectures of Employing Organisations

Moral architecture refers to the moral, ethical, human and employment rights obligations that organisations acquire in their commitment to delivering high-quality services, and as employers.[7] In order to establish and maintain moral architecture, it is necessary for each employing organisation to take account of its visions, priorities, structures, activities, leadership, management and conditions of staff employment and ensure that they are consistent with its stated roles and espoused values. This is part of the duty of the employing organisation to recognise the implied psychological contract they have with staff who undertake care on their behalf. Moral architecture can be assessed by how well employing organisations discharge their responsibilities and can be seen in, for example, its policies, their design and delivery of services, and their corporate governance.

Emotional Labour

Working with people who are affected by illness and personal problems requires emotional labour. Common experience is that, without the passion, commitment, carefully positioned relationships and emotional labour of staff, the quality of the care of patients is unlikely to be optimal generally and especially so in emergencies.[8]

Psychological Safety

The concept of psychological safety captures the degree to which people perceive their work environments as conducive to taking necessary interpersonal risks when doing their work. There is evidence that psychologically safe working environments are not only better for the wellbeing and welfare of the staff, but also less likely to result in errors of judgement or mistakes. Leaders should take responsibility for creating working environments that are as psychologically safe as is possible.

Collective and Personal Efficacy

In general, healthcare staff demonstrate a great ability to carry on working whatever the situation with which they are presented. They manage working with patients and all the primary stressors associated with that but also with the secondary stressors they experience.

As healthcare staff progress and gain increasing levels of expertise and experience, so does their sense of self-efficacy. This sense of self-efficacy contributes to aiding them to manage the stress in which they work and is associated with compassion satisfaction and active coping rather than avoiding difficult decisions and situations.

[7] Williams R, Kemp V, Neal A. Compassionate care: leading and caring for staff of mental health services and the moral architecture of healthcare organisations. In: D Bhugra, S Bell, A Burns (eds). Management for Psychiatrists (4th edn). RCPsych Publications; 2016; 377-402.
[8] Williams, R and Kemp, V. Caring for Healthcare Practitioners. BJPsych Advances. 2019, page 1 of 13 doi: 10.1192/bja.2019.66

An important aspect of how groups of people who work together cope is the concept of emotional containment which describes how strong emotions can be held or contained by a group or system without members realising or having to re-experience them. This can make staff feel supported and safe. The converse is also true with staff and can all-too-easily result in staff being left feeling unsafe and unsupported. In the circumstances of traumatic experiences, staff report that active coping does work.

Collective efficacy describes how teams choose to focus on actions, the effort they ascribe to them and how they perceive their abilities to accomplish their tasks. Job satisfaction and wellbeing are improved when there is a good sense of collective efficacy, of belonging to a work community and of feeling able to contribute effectively to satisfaction.

Employing healthcare organisations must attend actively to sustaining the health and wellbeing of their staff. Many factors contribute to effective approaches to wellbeing including the processes of managing and leading staff, recognising their emotional labour, augmenting teamwork and providing staff with social support. These approaches help to create a work environment wherein staff can develop and thrive and feel sustained to take on future challenges.

Leadership

Leadership of staff is an important factor in ensuring and maintaining staff efficacy as well as psychosocial care. Evidence shows that effective leadership raises the wellbeing of staff and reduces their rates of anxiety, depression, job stress and sick leave. It is based on a complex array of values, attitudes, qualities, perceptive skills and transactional and translational capabilities that create and communicate a vision of tasks.[9]

Team leaders have a particular role in ensuring the psychosocial wellbeing and efficacy of their team members by being aware of team members' psychosocial capabilities and training needs and by ensuring they receive professional supervision, effective management and psychosocial support. These actions help ensure that staff are working in situations that are psychologically safe and that contain staffs' emotions leaving them ready to take on new challenges.

Creating and running psychologically safe teams and sustaining healthcare staff requires leaders to:

- Be accessible and supportive
- Acknowledge fallibility
- Balance empowering other people with managing the tendencies for certain people to dominate discussions
- Balance psychological safety with accountability, physical safety and professionally safe practice and other components of strategic and clinical governance
- Guide team members through learning from their uncertainties
- Balance opportunities for their teams' reflection with action
- Have the capacity for emotional containment.

[9] Aitken P, Drury J, Williams R. Relationships, groups, teams and long-termism. In: R Williams, V Kemp, SA Haslam, et al (eds) Social Scaffolding; Applying the Lessons of Contemporary Social Science to Health and Healthcare. Cambridge University Press; 2019; 274-288.

We have observed that the impacts on staff of working in high-stress occupations may be considerable and we have written an overview of the impacts on responders of their being involved in disasters and major incidents.[10]

[10] Williams R, Kemp V. Psychosocial and mental health care before, during and after emergencies, disasters and major incidents. In: C Sellwood, A Wapling (eds). Health Emergency Preparedness and Response. CABI; 2016:82-98.